Medicare Statistical Files Manual

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MEDICARE STATISTICAL FILES MANUAL

This manual is prepared by the Division of Data Standards and Quality (DDSQ), of the Office of Statistics and Data Management (OSDM), Bureau of Data Management and Strategy (BDMS), Health Care Financing Administration (HCFA). The purpose of the manual is to provide information about the various statistical files available within HCFA concerning the Medicare program. It is intended to provide enough detail about each file so that persons interested in the Medicare program can determine what data are available. It is not designed for use by computer personnel to write programs or perform detailed systems design. Most files are annual files subject to limitations such as currency, changes in coding structure, changes in volume, changes in sample size, availability of information, legislative changes and others. The reader should bear in mind that not all files for a given reference period may be available for processing or resources may not be available to process them.

THE INFORMATION IN THESE FILES IS CONFIDENTIAL AND USED FOR ADMINISTRATIVE AND STATISTICAL PURPOSES ONLY. THE RELEASE OF ANY INFORMATION IS SUBJECT TO THE PRIVACY ACT AND OTHER FEDERAL GOVERNMENT RULES AND REGULATIONS.

Further information on the Medicare Statistical Files and data produced can be obtained by contacting the Director, Division of Data Standards and Quality, OSDM, BDMS, HCFA, Room 1-F-2 Oak Meadows Building, Baltimore, Maryland 21207.

Information Resource Center

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Medicare Statistical Files Manual

I. The Medicare Statistical System

Introduction

This Publication describes the various components of the Medicare data collection system. The information collected provides the basis of the statistical system designed to measure the effectiveness of the Medicare program. This system, by manipulating, summarizing and combining different types of records, produces a wide variety of files and tabulations for use by management and researchers. Knowledge of the benefits available under Medicare and of the way in which Medicare is administered will contribute to an understanding of the Medicare statistical program. Medicare is administered by the Health Care Financing Administration (HCFA), which also administers Medicaid and other Federal health programs. This new agency was formed in March 1977. Before that, the Social Security Administration (SSA) administered the Medicare program. Many functions, including the centralized computer operations, are still performed by SSA for HCFA.

Basic Provisions of Law

In 1965 amendments to the Social Security Act (Title XVIII) established two complementary health insurance programs for the aged--a hospital insurance (HI) plan (Part A) and a supplementary medical insurance (SMI) plan (Part B). The Part A plan provides coverage for hospitalization, stays in skilled nursing facilities, and home health services. The Part B plan provides coverage for physicians' services, outpatient hospital services, home health services and other medical services.

Benefit payments under both programs commenced July 1, 1966. Federally financed services in skilled nursing facilities began January 1, 1967. These benefits were originally available only to persons aged 65 and over. The 1972 amendments to the act established coverage for disabled persons under age 65 and for persons with End Stage Renal Disease (ESRD). Their payments began July 1, 1973.

The payment of HI benefits is geared to a benefit period (or "spell of illness"). A benefit period begins with the first day (not included in a previous benefit period) the individual is furnished inpatient hospital services or skilled nursing services. The first day of a benefit period must occur in a month for which the beneficiary is entitled to HI protection. The benefit period ends after 60 consecutive days during which the beneficiary is neither a hospital inpatient nor a skilled nursing facility inpatient. There is no limit to the number of covered benefit periods the individual may have as long as entitlement to health insurance continues.

The hospital insurance plan (Part A) provides inpatient hospital services up to a maximum of 90 days for each benefit period. Beneficiaries pay a deductible for the first 60 days of care and a coinsurance amount for each day thereafter for each benefit period. Each beneficiary also has a lifetime reserve of 60 extra days of hospital care beyond the 90 days allowed for each benefit period. The beneficiary, however, pays a portion of the charges for each of the additional lifetime reserve days used.

Each beneficiary is provided up to 100 days of care in a skilled nursing facility (SNF) for each benefit period, but only after a hospital stay of three days or more,and then only if the facility meets certain conditions. The insurance covers the costs of the first 20 days of care, and the beneficiary pays a daily coinsurance rate for the remaining 80 days. These benefits started in 1967. Prior to July 1981 up to 100 home health care visits annually, after discharge from a hospital or skilled nursing facility stay of at least 3 days, were covered. Effective July 1981 home health coverage under Medicare provides for unlimited visits, and the three days prior stay requirement was eliminated.

The SMI plan (Part B) covers such items as: physician services; diagnostic X-ray and laboratory tests; radium therapy; ambulance services; surgical dressings; other medical needs; and prior to July 1981 up to 100 home health care visits each year. Effective July 1981 unlimited home health visits are permitted but are considered Part B services only if beneficiary does not have Part A coverage. Home health only provided under Part B if the beneficiary does not have Part A coverage.

Generally, after a beneficiary pays an annual deductible, medical insurance will pay 80 percent of the reasonable charges for covered services for that year. However, for some services Medicare will pay 100 percent of covered reasonable charges; e.g. services performed in an independent laboratory that are billed on an assignment basis are reimbursed at 100 percent of a negotiated rate not subject to any deductible or coinsurance.

Fiscal Intermediaries

Under the HI program, intermediaries are selected by each institutional provider (hospitals, skilled nursing facilities, home health agencies) to act as the link between the provider and the Health Care Financing Administration. A vital role of the intermediaries is to review and pay claims for the cost of providing care to the beneficiaries. The intermediary makes these payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary use of covered services.

The reimbursement amount shown on institutional billing records is an interim payment made to the institution. Each institution is required to prepare a cost report at the end of its fiscal year and final reimbursement is made on a cost basis based on this report.

Carriers

Under the SMI program, carriers are selected by the Secretary of Health and Human Services. The principal functions of these carriers are to determine the reasonable charges in their respective areas for each medical care service paid for under the program and to review and pay claims to or on behalf of beneficiaries for the services provided.

The Health Insurance Master (HIM) file is updated daily for current maintenance and utilization information. Maintenance data consist of beneficiary enrollments and terminations; cross-reference of claim numbers; changes of address; and other changes which are received from the SSA and the Railroad Retirement Board master beneficiary record (MBR) systems. Utilization data consist of: notices of hospital admissions; SNF admissions; Part B deductible queries; provider billing records from intermediaries; and payment records from carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of HCFA's administrative processes.

Hospital Insurance Claims Process

The HCFA Central Office HI claims process operation is essential to provide current benefit and utilization information to intermediaries. It also monitors intermediary payment to institutional providers. When a beneficiary is hospitalized, the participating provider notifies the intermediary of the admission. The intermediary then transmits the information as a query to HCFA to check the beneficiary's status.

HCFA's Utilization Query and Reply Operations prepare the provider admission notices and other queries for subsequent processing in the update operations, and also prepare replies (from the update) for transmittal back to intermediaries. Interim and final bills completed by hospitals, skilled nursing facilities and home health agencies are submitted to the intermediary. Based on this information and the information furnished by HCFA in reply to an earlier query, the intermediary certifies payment to the provider.

The intermediary processes the information from the bills to magnetic tape and forwards them to HCFA. The taped bill records are then processed through various operations in HCFA.

Consistency Editing

This operation balances the number of bills and reimbursement amounts to the intermediary's total to establish acceptable tape totals for use through the remainder of the automated processing. A computer edit program identifies all invalid data and inconsistencies for each bill. Invalid data include such items as a month indicated by a number greater than 12, more than 60 lifetime reserve days used, and so forth.

The consistency edits do not compare data on the bills to information in HCFA records. These edits are used as a screen to check the consistency of data on the bill itself.

Utilization Editing

Once the consistency edits have been applied, the bills go through the utilization editing program. In this program, the bill data on the tape are compared to the data in HCFA's Health Insurance Master Record.

The bills in the batch which failed the consistency edits are screened in the utilization program for only three items.

- Name and claim number which match the master record
- Eligibility to Part A or Part B benefits during the billing period
- A matching open item on HCFA's Health Insurance Master Record. "Open" items are created from admission notices and are "Closed" by discharge bills or deletion queries.

Bills which have passed the consistency edits are processed completely through the utilization editing program, and are either posted or rejected. The detailed edits are described in Section 3830 of the Part A Intermediary Manual. This manual is maintained by the Bureau of Program Operations, HCFA.

Rejected bills are returned to intermediaries for correction and reinstatement (or voiding). Both bills and batches are held in the control system until their processing is completed or until they are deleted. Reports of batch processing, batch completion, and of outstanding returned bills are periodically sent to intermediaries to use in reconciling batches submitted and in checking on bills to be corrected and returned to HCFA. Records of the bills passing initial edits are passed on to the Beneficiary Master Update operation, which records the transactions on the individual's HI Master record, and generates records for updating the provider Master File, and to a history record of completed billing transactions. The update operation will also generate a beneficiary utilization notice where an interim or a final (discharge) bill is processed for inpatient services or home health visits.

Part A inpatient bill information is processed on an "in sequence" basis. This sequence is determined from the billing dates "from" and "to" present on each bill. Bills are processed in "from" date sequence within a benefit period.

A bill not related to a preceding open item (admission) will not be processed until the final bill for that open item is processed. All unprocessed bills are controlled so that any determination of a benefit period takes these unprocessed items into account, along with already processed or recorded items. (The HI Master record carries up to five of the most recent benefit periods in the beneficiary's record.) HCFA's reply to an intermediary admission notice or query shows benefit days remaining and deductibles to be met as of the last recorded date of discharge, or as of the last action, when there is an open item and interim billing has been received.

Medical Insurance Claims Process

Part B outpatient bills and Part B home health agency bills are submitted from intermediaries, while medical Payment Records are submitted from carriers. The processing procedure (Figure 3) differs from that for Part A bill records because, unlike Part A, Part B benefits are not tied to a benefit period with a limited number of days of care and varying coinsurance amounts. Under Part B, only physical therapy and psychiatric services have an annual limitation on benefits payable.

Claims for payment of Part B benefits are submitted to the carrier or intermediary by beneficiaries or the supplier of services (such as physicians). When the carrier or intermediary queries HCFA on the beneficiary's deductible status, the utilization query/reply operations handles the transaction similarly to Part A queries.

In addition, Part B queries update the Part B deductible, and record physical therapy and psychiatric expenses. The carrier or intermediary determines and makes payment to the claimant, taking into account the beneficiary's deductible status.

Carriers submit Payment Records for all physician and supplier claims for which payment is made. These Payment Records are batched and transmitted to HCFA, where they are edited, then matched against the HI Master Record to check for beneficiary entitlement and, if appropriate, to record physical therapy or psychiatric services. A listing of rejected records is returned to carriers for corrections and the records are held in a suspended record file. As records are corrected and returned, they are deleted from this file. In addition, another operation controls the batches of Payment Records and provides statistical reports on bill processing by each carrier.

The Explanation of Medicare Benefits (EOMB) is an important function of the carriers, and is used to notify each claimant for Part B benefits of the action taken on his claim. Section 7000 of the Medicare Carrier's Manual provides an in-depth description of the purpose and contents of the EOMB. This manual is maintained by the Bureau of Program Operations, HCFA.

Carriers send HCFA monthly reports of monies paid during the month for SMI services. Batches of Payment Records are matched against these carrier financial reports to determine if submitted records of payments by carriers balance HCFA's reimbursement to them for Part B payment made. HCFA then reconciles any differences.

HCFA does not receive bills for Part B services rendered by certain Group Practice Prepayment Plans (GPPP). These groups deal directly with HCFA and are reimbursed on a per capita cost basis. An attempt was made early in the statistical system to measure use by having these direct dealing GPPP's submit forms for each service rendered. However, this procedure proved inadequate and is no longer operational. Deductible for GPPP members (about 300,000) are updated by allocating one-twelfth of the deductible each month.

Part B Bill Summary Record-5 Percent Sample

A separate Medical Insurance statistical system was implemented July 1, 1975, to provide timely Part B data on the amount, type and cost of health care services. Carriers are required to prepare a Part B Bill Summary Record for each bill falling within a 5 percent sample for services incurred after December 31, 1974.

The Summary Record is prepared from bills submitted to the carriers. Records are based on the line items for each bill used by the carrier as input data in the preparation of the reasonable charge determinations, or in preparing the EOMB regardless of the deductible status of the beneficiary.

One Summary Record is prepared for each sample bill. If similar services are reported more than once on a bill, data are aggregated based on type and place of service. If services on a bill were performed in over-lapping years, separate Summary Records are prepared for each year.

After the Summary Records are prepared, carriers process all such records through an edit program provided by HCFA. This program checks consistency of the data and provides a report of the extent of errors. Carriers are expected to correct these errors before accumulating and submitting their monthly Summary Records to HCFA.

The Office of Statistics and Data Management of HCFA receives all Summary Records directly and processes them through an edit program similar to the one used by the carriers. Tapes containing excessive errors are returned to the carrier for corrections.

Provider Of Service Master File

Institutional providers of services (hospitals, SNF's and HHA's) participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing care for the beneficiaries of the two programs. The certification is done by State agencies according to HCFA guidelines and regulations. The qualifications are reviewed periodically, following the same procedure.

Source Documents and File Content

The State agency surveyor applies various criteria to measure an institution's capability of providing acceptable care. At the same time, provider characteristics such as staffing, number of beds and services provided are recorded on a forms package. This forms package is divided into two sets. The first set, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the institution being evaluated. For example, the surveyor evaluates such areas as staffing, physical environment, medical records, nursing, and dietary departments in hospitals and nursing homes. The second set comprises the source documents for the Provider of Service Master (POS) file, and includes the Certification and Transmittal Form (C&T) and the application form. The C&T Form records: address information; intermediary tie-in; and the certification decisions and certification approval dates of the State agency and the HCFA regional office. The application form contains the provider characteristics (type, control, staff, services, etc.).

Information Flow and Update Mechanism

When the on-site survey by the State agency surveyor has been completed, it is reviewed and approved by the State agency and forwarded to the HCFA regional office for review and final certification by the regional office. The reviewer ascertains that all forms are present and properly prepared. The data items that are prescribed for entry into the data base are then keyed to magnetic disk. The first group of consistency checks are applied as the data are entered. Incorrect entries alert the operator via a Cathode Ray Tube (CRT) display screen and for certain fields prevent further entry of the forms package in question until corrections are made. Those forms packages successfully keyed to the disk are batched daily in the regional office and transmitted via telephone lines to central office. A transaction record is built in central office by combining all the POS and SRF data elements into a single record for each provider of service. This record is next passed through a more extensive series of consistency checks for accuracy and completeness. The fully edited record is then entered into the provider of service master file.

The Medicare Statistical System

The primary objective of the Medicare Statistical System (MSS) is to provide data required to measure and evaluate the operation and effectiveness of the two parts of the Medicare program. The benefit payment operations furnish the means of obtaining extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by Medicare beneficiaries, as well as the costs of such services. The applications submitted by hospitals, skilled nursing facilities and home health agencies to participate in the Medicare program provide data on the characteristics of such providers of services. The claim number that is assigned to each beneficiary serves as the link between the various services used under the program and the demographic characteristics of each individual recorded in the enrollment files.

The data-collection system has two inherent characteristics that greatly determine the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records for each bill paid are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, time lags, costs, and the like, all program statistics are centrally prepared.

The statistical system is based on three record systems which are byproducts of the Health Insurance Administrative operations. These three systems are:

- The Health Insurance Master Enrollment Record-This record identifies each person (aged and disabled) enrolled for Medicare. Data describing the characteristics of the Medicare enrolled population are obtained from this file. This file also serves as the basis for obtaining Medicare utilization rates. Approximately 26 million aged beneficiaries and 3 million disabled beneficiaries are currently entitled to Medicare benefits.

- The Provider of Service Record-This file contains information on every hospital, skilled nursing facility, home health agency, independent laboratory and other institutional provider which must apply for participation in the program. Each is assigned a distinct provider mumber. Approximately 7,000 hospitals, 5,200 SNF's, 3,000 HHAs, 3,500 independent laboratories and 1,600 other types of facilities that participate in Medicare are on this file.

- The Utilization Record-Part A and Part B billing information is maintained centrally, and these records are tabulated monthly, quarterly, and annually to measure the use of Medicare services. While the annual volume of Medicare bills processed will vary from year to year, the approximate number processed in any year is as follows:

Inpatient hospital	12,000,000
SNF	800,000
Outpatient	26,000,000
HHA (A and B)	3.800,000
Payment Records (physicians and suppliers)	150,000,000

Since each record contains both the beneficiary's claim number and the provider's number, these records can be matched to the Enrollment and Provider records. By this process we can create statistical records that contain the information needed for tabulations from the three files.

The information in these files is confidential and used for administrative and statistical purposes only. The release of any information from these files is subject to the Privacy Act and other Federal Government rules and regulations. They are organized as weekly files in HI claim number sequence. Any requirement for individual records requires processing all weekly files for the desired time period. This is costly and time consuming and other sources such as intermediaries and carriers are recommended.

In addition to the one hundred percent utilization files described above, there are sample files for which diagnostic and surgery codes are obtained centrally at HCFA. These sample files are summarized in the following table:

Medicare Sample Sizes for Diagnosis and Surgical Procedure Coding

Type of Medicare Benefit	Billing Form	Sample Size
Inpatient Hospital	HCFA-1453	20% (100% effective October 1983)
Skilled Nursing Facility (SNF)	HCFA-1453	100%
Medical & Other Health Services (Outpatient)	HCFA-1483	5%
Home Health Agency-Part A and Part B	HCFA-1487	40%

Diagnostic Coding for Services thru 1970 - ICDA-7

Diagnostic Coding for Services 1971-1978 - ICDA-8

Diagnostic Coding for Services after 1978 - ICD-9-CM

Surgical Procedure Coding for years 1966-1978 - CPT

Surgical Procedure Coding for years after 1978 - ICD-9-CM, Volume 3

The information coded on each type of bill is as follows:

Inpatient Hospital - Principal diagnosis and principal surgical procedure (if any)

Inpatient SNF - Admitting diagnosis

Outpatient Hospital - Nature of illness and surgical procedure (if any)

Home Health Agency (A or B) - Diagnosis

HCFA also codes an indication (yes, no) of whether additional diagnoses or surgical procedures are indicated on the bill.

Before 1977, most intermediaries submitted hard copy bills to SSA, and coding was done manually. By 1977, almost all intermediaries were submitting claims to HCFA on magnetic tape. It became impractical to continue receiving hard copy bills for the sample claims. Therefore, all intermediaries were instructed to key the narratives from sample bills and report the information to HCFA as part of the claims tape record. The first 45 characters of diagnostic information and the first 41 characters of surgical information are currently reported.

HCFA codes the narratives using a process known as the Automated Medical Coding System (AMCS). This system consists of computer programs which match the narratives from the bills to a "dictionary" of pre-coded narratives. Where there is a match, the code is applied to the record. Narratives that are not matched to the dictionary are sent to a staff of trained coders for manual coding. HCFA updates the dictionary periodically by adding new narrative terms based on usage.

Since the development of the Medicare Statistical System, there have been many changes in the ability of hospitals to provide coded medical data, in the manner in which fiscal intermediaries collect and process claims data from providers, and in the uses made of the statistical data. Most hospitals code diagnoses and procedures using the clinical modification of the ninth revision of the International Classification of Disease (ICD-9-CM). These codes are used, for example, on hospital discharge abstracts to generate disease and operational indices; for research purposes; for reporting to rate setting agencies; and for other applications specific to each provider. At the same time, the fiscal intermediaries are encouraging providers to submit machine readable claims data to them and, as previously noted, all fiscal intermediaries now submit claims data to HCFA on tape.

Beginning in 1981, institutional providers were permitted, with the intermediaries' concurrence, to report codes instead of narratives. These codes must be the full ICD-9-CM codes and the intermediary must transmit to HCFA the original codes reported. Otherwise, the intermediary must transmit the original narratives, as reported by the provider, to HCFA.

In October 1983, hospitals were required to report only ICD-9-CM codes for inpatient hospital bills. Narratives were no longer permitted. Inpatient hospital bills were to contain codes for the principal diagnosis and up to four additional diagnoses, and principal surgical procedure and up to two additional surgical procedures, if any. Inpatient hospital bills also were required to contain a Diagnosis Related Group (DRG) number to determine reimbursement for prospective payment. Medicare bills other than inpatient hospital can still be reported using either narratives or codes and do not contain a DRG number.

The following chapters in this publication describe the major Medicare statistical files. The information in these files is confidential and used for administrative and statistical purposes only. The release of any of these files is subject to the Privacy Act and other federal government rules and regulations.

II. Enrollment

Introduction

This chapter describes the files used to obtain data on the total Medicare population and also various subpopulations of persons enrolled for Medicare benefits.

The Health Insurance Master File (HIM)

The Health Insurance Master File (HIM) identifies each person entitled to Medicare benefits. Entitlement may be for aged, disabled, or end stage renal disease whether a person is covered for hospital insurance benefits, supplementary insurance benefits or both. Data on age, sex, race and place of residence are obtained from this file.

For each person eligible for Medicare benefits a record is maintained in the HIM file. Identification of each record is based on the person's Social Security or Railroad Retirement Board claim number and a one or two position beneficiary identification code (BIC). The BIC portion of the claim number describes the type of benefit that entitles individuals to Medicare coverage. The most common BIC's are "A" for a primary wage earner, "B" for a wife age 65 or older and "D" for a widow age 65 or older.

The HIM file is updated daily for current maintenance and utilization information. Maintenance data consist of beneficiary enrollments and terminations, cross-references, changes of address and field changes which are received from the Master Beneficiary Record system of SSA and the Railroad Retirement Board. Utilization data consist of notices of hospital admission, queries, provider billing records, and payment records received from intermediaries and carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of HCFA's administrative process. This is illustrated in Exhibit A.

Health Insurance Skeleton Eligibility Writeoff File

To tabulate enrollment data a skeletonized version of the HIM file, known as the Health Insurance Skeleton Eligibility Writeoff (HISKEW) is created. The HISKEW file is produced quarterly from the HIM file.

A record format of this file, which includes a description of each field, is shown in Exhibit B. Approximately fifty million HISKEW records are created each quarterly processing period. This includes twenty million inactive (deaths) records.

Annual Enrollment Publication Tables

The annual enrollment tabulations showing the number of persons enrolled as of July 1 and the number of persons enrolled at any time in the year, are produced from the HISKEW file created as of March of the following year. For example, 1981 data are produced from the March 1982 HISKEW file.

The tabulations contain counts of aged, disabled, and end stage renal disease enrolles by:

1. Type of coverage (HI, SMI or both)

2. Age, race and sex

3. State of residence .

4. Residence in Standard Metropolitan Statistical Areas and Metropolitan and Non-Metropolitan counties

5. Number of persons newly enrolled or terminated during the year of the data.

In addition to the above, enrollees by county are shown as part of a publication containing enrollment and Medicare reimbursement by State and county. We also tabulate annual and quarterly data which are used for text tables, control tables and utilization rates but are not routinely published.

Special Population Groups

1. Railroad Retirement Board--A file of RRB beneficiaries entitled to Part A and/or Part B coverage is developed each year from the March HISKEW file. Enrollees are selected from this file based on RRB claim numbers. The entire HISKEW record is retained for each person selected. The file is used to obtain control data dnd can also be used to select records to study utilization of RRB enrollees.

2. State Buy-In Enrollment -- A State, through a buy-in agreement with HCFA, may enroll needy aged and disabled persons eligible for either public assistance or medical assistance programs for Part B coverage. Once buy-in eligibility in these programs is established, enrollment of an individual is involuntary on the part of the person even though he does not wish to enroll or has enrolled individually for Part B coverage; neither can he voluntarily terminate this coverage. A record for each enrollee is maintained in the HCFA Third Party Master file.

   This file is updated from records submitted by the State to HCFA of individuals to be added to or deleted from its coverage group. Those records to be added to the group are screened against the HIM file to determine if the person is eligible for Part B benefits. Matched records are annotated to indicate buy-in status in the HIM file, added to the Third Party Master file, and billing to the State is initiated.

   Each year a State buy-in membership "ever enrolled" file population is developed from the Third Party Master File. Records are selected for this file if a person is a buy-in at any time in the specified calendar year. For each person selected, a record is created containing the following information:

   a. HI claim number

   b. Date of birth

   c. Sex

   d. Race

   e. State of Residence at time file is created

   f. Cross-reference claim number

   g. Buy-in plan start date

   h. Termination date

   The file is summarized by age, race, sex, and State of Residence. Tables are prepared presenting these data based on the number of buy-ins enrolled at any time in a year and as of July 1 of each year.

3. Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's)

The Group Health Plan System (GHP) maintains a membership file for those GPPP's and HMO's that deal directly with HCFA for purposes of reimbursement and to control posting of deductible pro-rata amounts of each plan member entitled to Part B coverage. One-twelth of the Part B deductible is allotted to each member each month. Reimbursement to each plan for Part B services rendered to members is on a cost basis for GPPP's dealing directly with HCFA. A file of enrollees by plan is maintained by HCFA and is called the Health Insurance Control Group Health Plan Master file (HCGPMSTER). The HCGPMSTER file is updated by records submitted to HCFA by a GPPP. Each record is screened for Part B eligibility against the HIM file and processed to the HCGPMSTER file.

Annual Enrollment data are developed only for those plans dealing directly with HCFA. Records are selected from the HCGPMSTER file containing the following information:

a. HI claim number

b. Date of birth

c. Sex

d. Race

e. State of Residence at time file is created

f. Cross-reference claim number

g. Plan start date

h. Termination date

i. GPPP plan number

This information is summarized by age, race, sex, GPPP plan and State of Residence. Tables are prepared presenting data on the number of persons enrolled at any time in a year and as of July 1 of each year.

Exhibit A--Health Insurance Master Beneficiary Record--Enrollment and Utilization Maintenance

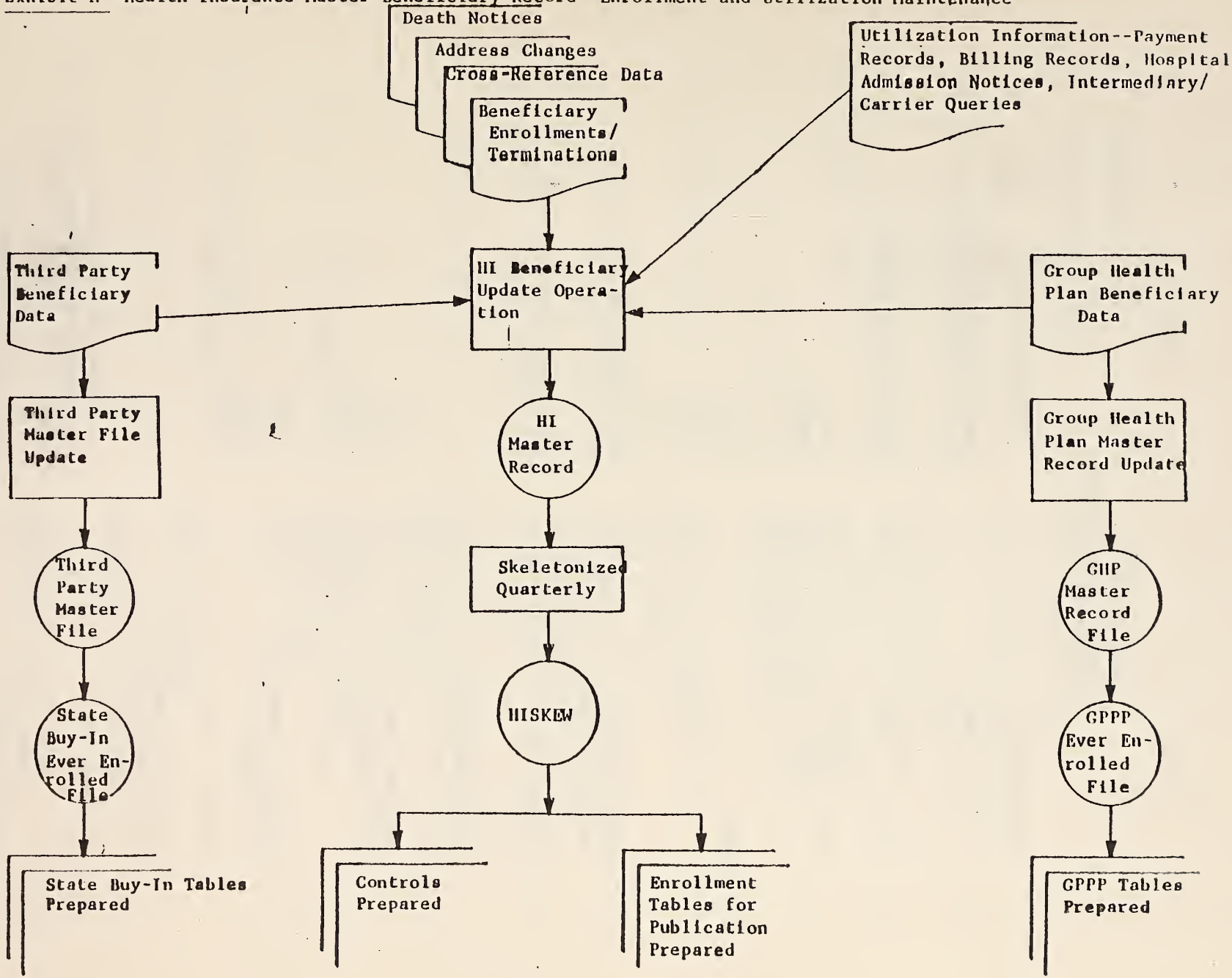

Exhibit B

HISKEW Record Contents

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Date of Birth	Year and Julian date of beneficiary's birth
3.	Sex	-Male -Female -Unknown
4.	Race	-White -Black -Other -Unknown
5.	State Code of Residence	SSA Geographic code book Publication 026
6.	County Code of Residence	SSA Geographic code book Publication 026
7.	Cross-reference Claim Number	
8.	Original Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
9.	Current Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
10.	Dual Entitlement to SSA and RRB benefits	-No -Yes
11.	Previous BIC	Indicates any previous type benefits paid to beneficiary
12.	Date of Death	Year and Julian date of beneficiary's death

Exhibit B

Information	Description
13. Current Part A Data	
a. Entitlement	Year and Julian date
b. Termination	Year and Julian date
14. Current Part B Data	
a. Entitlement	Year and Julian date
b. Termination	Year and Julian date
15. Coverage Code	-No coverage or deceased -Part A entitlement only -Part B entitlement only -Part A and Part B entitlement
16. Termination Code A	Reason for termination to Part A entitlement: -Not terminated -Dead -Non-payment of premium -Voluntary withdrawal -Entitlement under another claim number -Other termination
17. Termination Code B	Reason for termination to Part B entitlement: -Not terminated -Dead -Non-payment of premium -Voluntary withdrawal -Entitled under another -claim number -Other termination
18. Prior Part A Data	
a. Entitlement	Year and Julian date of latest prior entitlement
b. Termination	Year and Julian date of latest prior termination
19. Prior Part B Data	
a. Entitlement	Year and Julian date of latest prior entitlement
b. Termination	Year and Julian date of latest prior termination

Exhibit B

	Information	Description
20.	Bill Code	Coded to indicate party paying SMI: -Individual -Public Assistance -Private Third Party -Civil Service
21.	ZIP Code of Residence	Actual
22.	Day 01 Indication	Coded to indicate if beneficiary born on the first day of the month -Yes -No
23.	End Stage Renal Disease Indication	Coded to indicate method of original notice of ESRD -MBR Notice of ESRD -HI Notice of ESRD -NIH Notice of ESRD -MBR and HI Notice of ESRD -MBR and NIH Notice of ESRD -HI and NIH Notice of ESRD -MBR, HI, and NIH Notice of ESRD
24.	Century of Birth Indicator	-Prior Century -Current Century

III. Provider of Services Master File

Introduction

Institutional providers of service (hospitals, SNF's etc.), participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing safe and effective care for the beneficiaries of the two programs. The certification procedure is conducted-under federal guidelines-by an agency of the state where the institution is located. Final approval comes from the Health Care Financing Administration. After the initial certification, the qualifications of an institution are reviewed periodically, culminating in a decision to retain or terminate participation.

Source Documents and Input

The observations and decisions of the State agency surveyors, when applying the various criteria which measure an institution's capability of providing acceptable care, as well as characteristics such as staffing, bed size and services, are recorded in a forms package. This package is divided into two sets: the first, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the particular institution. The second set comprises the source documents for the Provider of Services (POS) Master File and includes the certification and transmittal (Exhibit A) and the application (Exhibit B). A separate version of the application form is used for each type of provider (hospital, LTC, HHA, etc.)

The complete forms package (POS and SRF) is converted on a flow basis to magnetic disk in the HCFA regional office where the files of the original source documents are maintained.

Update Mechanism and Quality Control Measures

The update cycle for the POS/SRF system is daily. Once a day the keyed data from all the regions are wire tramsmitted directly to the Bureau of Support Services. The keyed data are sorted, and transaction records (accretion, correction, termination) are built by combining all the POS and SRF data elements into a single record for each provider of service. This record is then passed through a series of computer consistency checks which examine the record for such error possibilities as dates outside acceptable ranges, disagreement of provider number with type of facility indicators, absence of staffing to provider services indicated, incorrect codes, and many others. Exhibits C and D detail the record contents of the POS portion for hospitals and LTC's respectively. Record contents for the HHA portion are shown in Exhibit E. During this phase of the update system, a segment indicating errors discovered is appended to the transaction record.

The transaction record is then match/merged to an orbit file of earlier transactions which could not be applied to the master data base due to an error, and await correction by the Regional Office. New transactions are added to the orbit file and corrections overlay the matching orbit record.

Next, the orbit file is passed against the POS/SRF master data base; accretions without error are added to the data base; recertifications replace the associated earlier certifications, which are placed on a separate history file; corrections and termination actions overlay or add the prescribed data elements to the existing record. All new transactions, including those that failed to pass the consistency check, those that failed to match the master data base, and those that were successfully applied to the master data base, are transmitted over the telecommunication network to the regional office. The entire process is set to a daily schedule so that the regions receive the disposition of the records they originally transmitted the morning following their transmission to central office.

In addition to the computer consistency checks, OSDM performs monthly a manual check of selected fields of all transactions applied to the POS portion of the master data base. Periodic notes are sent to the regions showing erroneous transactions which are still uncorrected and on the orbit file after a specified time period.

Dependent Systems and Outputs

The POS file is used to support a number of Health Insurance administrative data processing systems. These include the following:

1. The Directory of Medical Facilities

   This is a compendium of participating and non-participating medical care institutions which is used primarily by the intermediaries for admission approval and spell-of-illness determination.

2. The Update of the Provider Master File

   The POS file furnishes provider records to the system which posts bill information to the records to produce the Provider Statistical and Reimbursement Report and the Provider Monitor Listing. The former is used as an audit tool at time of cost settlement and the latter for program review.

3. Provider Cost Report Monitoring System

   The POS file serves as a control file for this system which monitors the progress of cost reports through the various stages of audit and settlement.

4. Prospective Limits on Provider Costs

   The POS file is used for addressing information and provider characteristics such as bed size and geographic location which are factors in the grouping of providers for computing limits of reimbursable costs by the Bureau of Program Policy.

Recurring tabulations and analyses based on information from the POS file are published on an annual basis. Various listings and tabulations have been produced to satisfy requests from private organizations, other components of HCFA and DHHS, and the Congress. A version of the POS tape file is also prepared in a format suitable for use as input to the table generating software package, which is another means of servicing one-time special requests.

ARTMENT OF HEALTH AND HUMAN SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

EXHIBIT A

PART I - To be completed by State Survey Agency

1. MEDICARE/MEDICAID PROVIDER NO. (L 1)

2. STATE VENDOR NUMBER/MEDICARE/MEDICAID I.D. NO. (L 2)

3. NAME AND ADDRESS OF FACILITY (L 3) (L 4) (L 5) (L 6)

4. TO HCFA REGIONAL OFFICE

TO TITLE XIX SINGLE STATE AGENCY

5. CATEGORY OF PROVIDER/SUPPLIER (L 7)

01 ☐ Gen. Hosp. 04 ☐ SNF 07 ☐ Portable X-Ray 10 ☐ ICF 13 ☐ PTIP
02 ☐ Psych. Hosp. 05 ☐ HHA 08 ☐ Outpatient PT/SP 11 ☐ ICF/MR
03 ☐ TB Hosp. 06 ☐ Independent Lab. 09 ☐ ESRD 12 ☐ RHC

6. TYPE OF ACTION (L 8)

1 ☐ Initial 3 ☐ Reconsideration
2 ☐ Recertification 4 ☐ Change of Ownership

7. EFFECTIVE DATE OF CHANGE OF OWNERSHIP (L 9)

8. ACCREDITATION VERIFIED (Hospitals) (L 10) 1 ☐ JCAH 2 ☐ AOA

9. DATE OF SURVEY (L 34)

10. CHANGE IN ACCREDITATION-BASED CERTIFICATION (Hospitals) (L 11)

1 ☐ Gained Accreditation 2 ☐ Lost JCAH Accreditation 3 ☐ Lost AOA Accreditation

11. SPECIAL STATE AGENCY SURVEYS OF JCAH/AOA HOSPITALS (L 36)

1 ☐ Sample Validation 2 ☐ Monitoring Hosp. Because of Validation Survey Results 3 ☐ Complaint Investigation 4 ☐ Monitoring Hosp. Because of Complaint Investigation Survey Results

12. PURSUANT TO PROVISIONS OF SEC. 1864 AND APPLICABLE PROVISIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT AND UPON CONSIDERATION OF ALL FACTS THE FACILITY IS CERTIFIED AS.

(A) ☐ In compliance with program requirements (If appropriate, check applicable boxes below) and/or approved waiver(s) of the following requirements

Compliance is based on:

(1) ☐ Acceptable P.O.C.
(2) ☐ 42 CFR 405.1910 (Access Provision)
(3) ☐ 24 Hour RN
(4) ☐ 1861(j)(15)(7 day RN rural SNF)
(5) ☐ Life Safety Code
(7) ☐ Medical Director
(8) ☐ Patient Room Size
(9) ☐ Beds Per Room

(B) ☐ Not in compliance with program requirements (complete item 17)

(C) ☐ Deferred Approval of Termination (Non-accredited hospitals only)

Until: ____ (See Remarks)

(D) LTC Cancellation Date is:
(1) ☐ Invoked (2) ☐ Rescinded

(L 12)

13. LTC PERIOD OF CERTIFICATION
(a) From: (L 13)
(b) To:
(c) LTC cancellation date (L 14)

14. SUPPLEMENTAL INFORMATION FOR HOSPITALS AND SNF'S NOT IN COMPLIANCE AND "ALL" ICF'S. (L 15)

(a) Hospital meets emergency services hospital definitions (1) ☐ Yes (2) ☐ No
(b) Facility meets 1861(e)(1)—Definition of hospital (1) ☐ Yes (2) ☐ No
(c) Facility meets 1861(i)(1)—Definition of spell of illness (1) ☐ Yes (2) ☐ No

15. SUPPLEMENTAL ICF INFORMATION 42 CFR 442.115.

Completion Date for ICF/MR LSC Compliance

(L 16)

16. TOTAL AND CERTIFIED BEDS (Include swing beds)

BEDS CERTIFIED (L 17)

TOTAL BEDS (L 18)

IF FACILITY CERTIFIED UNDER ABOVE PROVIDER NUMBER HAS MULTIPLE CATEGORIES OF BEDS, ENTER THE CERTIFIED BED TOTALS IN FIELDS L37 TO L40.

18 ONLY BEDS	18/19 BEDS	19 ONLY BEDS	SNF/ICF SWING BEDS
(L 37)	(L 38)	(L 39)	(L 40)

17. STATE SURVEY AGENCY REMARKS

18. SURVEYOR SIGNATURE | 19. DATE (L 19) | 20. STATE SURVEY AGENCY APPROVAL | 21. DATE (L

TITLE | TITLE

PART II - To be completed by HCFA Regional Office, Single State Agency or State Survey Agency (if applicable)

22. DETERMINATION OF ELIGIBILITY (L 21)

1 ☐ Facility is eligible to participate
2 ☐ Facility is not (or no longer) eligible to participate (If Title XIX - explain in remarks) Item No. 28

23. ☐ Facility is in compliance with Title VI of Civil Rights Act (L 22)

24. (L 23)

1 ☐ Statement of financial solvency filed in accordance with regulation 42 CFR 405.603.
2 ☐ Disclosure of financial interest/ownership information

25. EFFECTIVE DATE OF: (Enter All Applicable)

(a) PARTICIPATION (ORIGINAL)	(b) LTC AGREEMENT BEGINNING DATE	(c) LTC AGREEMENT ENDING DATE	(d) LTC CANCELLATION DATE	(e) SNF/ICF AGREEMENT EXTENDED UNDER SEC. 1866(e)(1)(C) UNTIL (MAXIMUM OF 60 DAYS):	(f) TERMINATION OR NON-RENEWING DATE
(L 24)	(L 41)	(L 25)	(L 26)	(L 27)	(L 28)

26. TERMINATION ACTION (L 30)

1. ☐ Closure/Merger
2. ☐ Voluntary Withdrawal
3. ☐ Involuntary Termination
7. ☐ Failure to meet Agreement
8. ☐ Non-participating Status Change
9. ☐ LTC Status Change

27. INTERMEDIARY/CARRIER NUMBER (L 31)

28. REMARKS

29. HSQ/RO RECEIPT OF HCFA-1539 (L 32)

30. FISCAL YEAR ENDING DATE (L 35)

31. DETERMINATION APPROVED

32. DATE (L 33)

FORM HCFA 1539 (11-80)

SURVEY STATE AGENCY CONTROL 25

DEPARTMENT OF HEA AND HUMAN SERVICES
Health Care Financing Administration

FORM APPROVED
OB No. 0938 0103

HOSPITAL/REQUEST FOR CERTIFICATION IN THE MEDICARE AND/OR MEDICAID PROGRAM

Hospitals accredited by the JCAH or AOA may establish their eligibility to provide services for reimbursement under the program by submitting to the designated State agency information on this form.

REQUEST TO ESTABLISH ELIGIBILITY IN (M55) 1 ☐ Medicare 2 ☐ Medicaid 3 ☐ Both	MEDICARE/MEDICAID PROVIDER NO. (M1)	STATE/COUNTY CODE (M2)	STATE REGION (M3)	RELATED PROVIDER NUMBER (M9)

I. Identifying Information

NAME OF HOSPITAL	STREET ADDRESS	
CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NUMBER (M7)

II. Type of Hospital *Check one that most accurately describes* (M12)

1 ☐ General-Short Term
2 ☐ General-Long Term
3 ☐ Psychiatric-Short Term
4 ☐ Psychiatric-Long Term
6 ☐ Specialty-Short Term
7 ☐ Specialty-Long Term
8 ☐ Christian Science Sanitorium

III. Type Of Control *(Check one)* (M13)

Voluntary Not For Profit	Government (Non-Federal)	
1 ☐ Church	4 ☐ State	6 ☐ City
2 ☐ Other *(Specify)*	5 ☐ County	7 ☐ City-County
3 ☐ Proprietary	9 ☐ Government (Federal) *(Specify)*	8 ☐ Hospital District or Authority

IV. Physician Training Programs

A. Affiliated with a Medical School (M49)
1 ☐ Major
2 ☐ Limited
3 ☐ Graduate
4 ☐ No Affiliation

B. Resident Programs Approved by: (M51) *(Check Blocks)*
1 ☐ AMA
2 ☐ ADA
3 ☐ AOA
4 ☐ Other
5 ☐ No Program

V. Services provided by Staff. *(Place a "1" in appropriate block(s). If services provided under arrangements place a "2" in the appropriate block(s))* (M19)

01 ☐ Blood Bank	08 ☐ Physical Therapy Dept.	15 ☐ Medical Social Service Department	21 ☐ Extended Care Unit	29 ☐ Pulmonary Function Service
02 ☐ Clinical Laboratory	09 ☐ Intensive Care Unit	16 ☐ X-Ray, Diagnostic	22 ☐ Renal Dialysis	30 ☐ Organ Bank
03 ☐ Pathology Laboratory	10 ☐ Organized Outpatient Department	17 ☐ Nuclear Medicine	23 ☐ Open Heart Surgery	31 ☐ Ambulatory Pre-operative Unit
04 ☐ Electrocardingraph	11 ☐ Emergency Department	18 ☐ Cobalt & Radiation Therapy	24 ☐ Coronary Care Unit	32 ☐ Nursery
05 ☐ Electroencephalograph	12 ☐ Home Care Unit	19 ☐ Psych Inpatient Care	25 ☐ Oral Surgery Department	33 ☐ Shock Trauma
06 ☐ Pharmacy	13 ☐ Operating Room	20 ☐ Rehabilitation Unit	26 ☐ OB GYN Department	
07 ☐ Occupational Therapy	14 ☐ Recovery Room		27 ☐ Pediatric Department	
			28 ☐ Speech Therapy Department	

VI. Number of Employees *(Full-time equivalents)*

Physicians (salaried only) (M20)	Registered Professinnal Nurses (M27)	Registered Pharmacists (M40)	Occupational Therapists (M42)	Physical Therapists (M44)
Residents (M24)	Licensed Practical Nurse/Licensed Vocational Nurses (M28)	Medical Social Workers (M41)	Speech Therapists (M43)	All Other (M54)

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

NAME OF AUTHORIZED REPRESENTATIVE & TITLE (TYPED)	SIGNATURE	DATE (M53)

EXHIBIT B

Provider of Services Hospital Record

Exhibit C

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are the State code. Positions 3 and 4 are coded as follows: 00-08--short stay hospital 09--multi hospital complex 18--neighborhood health center 19--Christian Science 20-22--long stay 40-49--psychiatric D0-D9--denied participation M0-M9--not participating but meets Medicare definition of a hospital P0-P9--not participating and does not meet Medicare definition of a hospital Positions 5 and 6 are numeric except for emergency and Federal hospitals which are coded E & F, respectively, in the 6th position
2.	Intermediary Number	Number identifying the hospital's intermediary
3.	Effective Date of Participation	Date hospital entered Medicare program
4.	Date of Application	Date when hospital initially applied for participation
5.	Surveyor Date	Date when State surveyor completed examination of hospital
6.	State Survey Agency Approval Date	Date State approved survey of hospital
7.	Termination Date	Date hospital was terminated from program

Exhibit C

Information	Description
8. Determination Approved Date	Date Regional Office approved State findings
9. Regional Office Receipt Date	Date Regional Office received survey
10. Category of Provider	-General hospital -Psychiatric hospital -Christian Science
11. Type of Action	-Initial certification -Recertification -Reconsideration -Change of Ownership
12. Eligibility Determination	-Eligible -Ineligible to participate
13. Title VI Compliance	-In compliance -No information
14. Statement of Financial Solvency	-Settlement filed -No information
15. Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary withdrawal -Failure to abide by agreement -Emergency hospital changed to full participation

Exhibit C

	Information	Description
16.	Supplemental Information on Hospitals not in Full Compliance	-Emergency hospital -Not emergency hospital -Meets Medicare definition -Does not meet Medicare definition
17.	Status of Compliance with Program Requirements	Coded indications showing basis for compliance to regulations. Information available upon request
18.	Certified Beds	Number of certified beds
19.	Total Beds	Total number of beds
20.	Name of Hospital	
21.	Street Address	
22.	City and State	
23.	Zip Code	
24.	Type of Hospital	-General short Term -General long term -Psychiatric short term -Psychiatric long term -Specialty short term -Specialty long term -Christian Science
25.	Type of Control	-Church -Other voluntary non-profit -Proprietary -State -County -City -City/County -Hospital district -Federal
26.	State Code of Hospital	-SSA geographic code indicating State of hospital's residence

Exhibit C

	Information	Description
27.	County Code of Hospital	SSA geographic code indicating county of hospital's residence
28.	State Region Code of Hospital	Code assigned by States who divide themselves into regions
29.	PSRO Code	Code identifying PSRO area within State
30.	Authorized Date	Date when application was completed
31.	Fiscal Year Ending Date	Date on which fiscal year ends
32.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one
33.	Previous Intermediary Number #2	Prior to previous intermediary #1
34.	Health Service Area Code	
35.	Intermediary Type	-HCFA -Blue Cross -Group health -Commerical -State agency -Other
36.	Provider Number of Parent Organization	
37.	Previous Provider	If the institution changed status, e.g., long term to short term, the previous provider number is placed here
38.	Status Code	-Accretion (initial) record -Change or correction including resurvey -Delete -Terminated

Exhibit C

	Information	Description
39.	Last Transaction Code	-Initial -Resurvey -Correction
40.	Participation Code	Indicates type of program participation: -Medicare -Medicaid -Medicare and Medicaid -Non-Participation
41.	Facility Group	Hospital
42.	Region Code	HCFA region
43.	SMSA	Standard Metropolitan Statistical Area code
44.	SMSA Size Code	Code categorizing size by Census population
45.	Run Date of Accretion	Date when initial record entered system
46.	Run Date of Last Transaction	Date last transaction entered system
47.	Change of Ownership Count	Number of times the facility has changed ownership
48.	Resurvey Count	Number of resurveys conducted under present ownership
49.	Prior Owner's Dates	-Change of ownership -Certification -Termination
50.	Survey Date	Date of survey
51.	Resident Programs Approved	Four position field. First position-AMA, second position-ADA, third position-AOA, fourth position-other. Each position coded "1" for approval, "0" for not approved or no program

Exhibit C

Information	Description
52. Facilities and Services	Thirty-three position field. Each position coded as follows:
1-Blood bank	-Provided by staff
2-Clinical laboratory	-Provided under arrangement
3-Pathology laboratory	-Not provided
4-Electrocardiograph	
5-Electroencephalograph	
6-Pharmacy	
7-Occupational therapy department	
8-Physical therapy department	
9-Intensive care unit	
10-Organized outpatient department	
11-Emergency care	
12-Home care unit	
13-Operating room	
14-Post operative recovery room	
15-Medical social service department	
16-X-Ray, diagnostic	
17-Nuclear medicine	
18-Cobalt and radiation therapy	
19-Psychiatric and inpatient care unit	
20-Rehabilitation unit	
21-Extended care unit	
22-Renal dialysis	
23-Open heart surgery	
24-Coronary care unit	
25-Oral surgery	
26-Obstetrics-Gynecology department	
27-Pediatric department	
28-Speech therapy department	
29-Pulmonary function department	
30-Organ bank	
31-Ambulatory pre-operative unit	
32-Nursery	
33-Shock trauma	

Exhibit C

	Information	Description
53.	Salaried Physicians	Number of physicians salaried by hospital
54.	Number of Employees by Type	
	Registered nurse	
	Licensed practical nurse	
	Pharmacist	
	Social worker	
	Occupational therapist	
	Speech therapist	
	Physical therapist	
	Other employees	
	Total staff	
55.	Affiliation with a Medical School	-Major -Limited -Graduate -No affiliation
56.	Accreditation Verified	-JCAH accredited -AOA accredited -Not accredited or no information
57.	Change in Accreditation	-Gained accreditation -Lost JCAH accreditation -Lost AOA accreditation -No change
58.	Date Approved for Emergency Services	Approval date for hospitals with E in sixth position of provider number
59.	JCAH Survey Date	Date surveyed by the Joint Commission on Accreditation of Hospitals
60.	Indicator of State and Survey of JCAH/AOA Hospitals	-Sample validation -Monitoring hospital -Complaint investigation -Monitoring because of complaint results
61.	Emergency Election Code (Emergency Hospitals only)	-Emergency hospital does not elect participation -Emergency hospital elects participation

Provider of Services Long Term Care Record

Exhibit D

Information	Description
1. Provider Number	Six position number identifies a specific facility. First two positions are State code. Positions 3 and 4 are coded as follows: 50-54, 60-64: Medicare participating SNF's 69: Christian Science A0-A9, B0-B9: Medicaid only participating SNF's E0-E9, F0-F9: Medicaid participating ICF's G0-G9: Medicaid participating IMR's R0-R9: Non-participating, does not meet definition of a SNF X0-X9, and Y0-Y9: Non-participating, meets definition of a SNF Positions 5 and 6 are always numeric
2. Intermediary Number	Number identifying the Medicare intermediary for a participating LTC
3. Effective Date of Participation	Date LTC entered Medicare Program
4. Date of Application	Date when LTC initially applied for participation
5. Surveyor Date	Date when State surveyor completed examination of LTC
6. State Survey Agency Approval Date	Date State agency approved survey of LTC

Exhibit D

	Information	Description
7.	Termination or Non-Renewing Date	Date LTC was terminated from Medicare program or contract was not renewed
8.	Determination Approved Date	Date Regional Office approved State findings
9.	Regional Office Receipt Date	Date Regional Office received survey
10.	Category of Provider	-SNF -Christian Science -ICF (Intermediate Care Facility) -IMR (Institution for the Mentally Retarded)
11.	Type of Action	-Initial certification -Recertification -Reconsideration -Change of ownership -Validation -Investigation
12.	Eligibility Determination	-Eligible -Ineligible to participate
13.	Title VI Compliance	-In compliance -No information
14.	Statement of Financial Solvency	-Statement filed -No information
15.	Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary, no longer meets requirements -Failure to abide by agreement -LTC status change
16.	Supplemental Information on Facilities not in Full Compliance	-Meets definition of a LTC -Does not meet definition -Part of facility meets definition of a LTC

Exhibit D

Information	Description
17. Status of Compliance with Program Requirements	Coded indicators showing basis for compliance to regulations defining LTC's. Details available upon request
18. Certified Beds	Coded to indicate LTC category -Medicaid SNF -Medicare/Medicaid SNF -Medicare SNF -ICF -IMR -LTC category will be followed by number of beds certified for that facility
19. Total Beds	
20. Name of Facility	
21. Street Address	
22. City and State	
23. Zip Code	
24. Type of LTC Facility	-SNF -SNF unit of hospital -SNF unit of rehabilitation center -SNF unit of domiciliary institution -SNF distinct part of SNF -Christian Science -General ICF -ICF distinct part of SNF -SNF/ICF (swing bed) -ICF/MR -ICF/MR DP of hospital -ICF/MR DP of SNF -ICF DP of hospital -ICF DP of ICF -ICF/MR DP of ICF/MR

Exhibit D

	Information	Description
25.	Type of Control	-Church -Other non-profit -Proprietary -State -County -City -City/County -Hospital district
26.	State Code of LTC	
27.	County Code of LTC	
28.	State Region Code of LTC	-Code assigned by States who divide themselves into regions
29.	PSRO Code	
30.	Authorized Date	Date when application was completed
31.	Fiscal Year Ending Date	Date on which fiscal year ends
32.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one
33.	Previous Intermediary Number #2	Prior to previous intermediary #1
34.	Health Service Area Code	
35.	Intermediary Type	-HCFA -Blue Cross -Group health -Commercial -State Agency -Other
36.	Provider Number of Parent Organization	
37.	Previous Provider Number	If the institution changed status, e.g., IMR to SNF, the previous provider number is placed here

Exhibit D

	Information	Description
38.	Status Code	Accretion (initial) record Change or correction including resurvey Delete Terminated
39.	Last Transaction Code	Initial Resurvey Correction
40.	Participation Code	Medicare Medicaid Medicare and Medicaid Non-participating
41.	Facility Group	Long term care
42.	Region	HCFA region
43.	SMSA	Standard Metropolitan Statistical Area code
44.	SMSA Size Code	Code categorizing size by Census population
45.	Run Date of Accretion	Date when initial record entered system
46.	Run Date of Last Transaction	Date last transaction entered system
47.	Change of Ownership Count	Number of times the facility has changed ownership
48.	Resurvey Count	Number of surveys conducted under present ownership
49.	Survey Date	Date on site Certification survey was conducted
50.	Prior Owner's Date	-Change of ownership -Certification -Termination
51.	Program Eligibility	-Medicare -Medicaid -Both

	Information	Description
52.	Number of Employees in Certified Part by Type	
	Registered Professional Nurse	
	Licensed Practical Nurse	
	Total Staff	
	All others	
53.	Services	Seventeen position field. Each position coded as follows:
	1-Nursing	-Provided by staff
	2-Physical therapy	-Provided under arrangement
	3-Outpatient physical therapy	-Not provided
	4-Occupational therapy	
	5-Speech pathology	
	6-Outpatient speech pathology	
	7-Social services	
	8-Recreational activities	
	9-Pharmacy	
	10-Clinical laboratory	
	11-Diagnostic X-Ray	
	12-Administration and storage of blood	
	13-Dentistry	
	14-Podiatry	
	15-Ophthalmology	
	16-Psychological services	
	17-Other	
54.	Completion Date for ICF Life Safety Code Compliance	
55.	SNF/ICF Period of Certification	
	From Date	
	To Date	
56.	SNF/ICF Cancellation Date	Date (YR-MO-DA) when contract with SNF/ICF is cancelled

Exhibit D

Information	Description
57. Agreement Ending Date	Date RO designates as date Medicare contract ends
58. Cancellation Date	Date (YR-MO-DA) RO designates for cancellation of Medicare contract
59. SNF/ICF Agreement Date	Date beyond normal ending date granted to correct deficiencies
60. Distinct Part Indicator	-Facility contains a certified distinct part -Facility does not contain a certified distinct part
61. Number of Beds--Total Facility	
62. Number of Employees Entire Facility Registered professional nurses Licensed practical nurses Total Staff All others	
63. Medicaid Termination Date	Date LTC was terminated from Medicaid participation
64. Number of Title 18 certified beds	Title 18 is Medicare, Title 19 is Medicaid
65. Number of Title 18/19 certified Beds	
66 . Number of Title 19 certified beds	
67. Number of SNF/ICF Swing Beds	Same beds certified for either SNF or ICF utilization depending on status of occupant
68. Agreement Beginning Date	Date agreement to participate was executed with HCFA

Provider of Services Home Health Agency Record

Exhibit E

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are the State code. Positions three and four are coded as follows: 70-77 individual HHA; 78 subunit of a State-wide HHA. Positions five and six are numeric.
2.	Intermediary Number	Number identifying the HHA's intermediary
3.	Effective Date of Participation	Date when HHA entered Medicare program
4.	Date of Application	Date when HHA initially applied for participation
5.	Surveyor Date	Date when State surveyor completed examination of HHA
6.	State Agency Survey Approval Date	Date State agency approved survey of HHA
7.	Termination Date	Date HHA was terminated from the program
8.	Determination Approved Date	Date Regional Office approved State findings
9.	Regional Office Receipt Date	Date RO received survey
10.	Type of Action	-Initial certification -Recertification -Reconsideration -Change of ownership -Validation -Investigation
11.	Eligibility Determination	-Eligible -Ineligible to participate
12.	Title VI Compliance	In compliance No Information

Exhibit E

	Information	Description
13.	Statement of Financial Solvency	-Statement filed -No information
14.	Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary -Failure to abide by agreement
15.	Name of Facility	
16.	Street Address	
17.	City and State	
18.	Zip Code	
19.	Type of HHA	-Visiting Nurse Association -Combination government and voluntary agency -Official health agency -Rehabilitation facility based program -Hospital based program -SNF based program -Proprietary -Private nonprofit -Other
20.	Type of Control	-Voluntary nonprofit other than church -Church -State government -Local government -Combination government and voluntary -Proprietary -Private non-profit

Exhibit E

	Information	Description
21.	State Code of HHA	SSA geographic code indicating State of HHA's residence
22.	County Code of HHA	SSA geographic code indicating county of HHA's residence
23.	State Region Code	Code assigned by States who divide themselves into regions
24.	PSRO Code	
25.	Authorized Date	Date when application was completed
26.	Fiscal Year Ending Date	Date on which fiscal year ends
27.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one
28.	Previous Intermediary Number #2	Number of intermediary prior to previous intermediary #1
29.	Switch Date of Intermediary	Date of last intermediary change
30.	Intermediary Type	-HCFA -Blue Cross -Group Health -Commercial -State Agency -Other
31.	Provider Number of Parent Organization	
32.	Previous Provider Number	If the institution changes status, e.g., SNF to HHA, the previous provider number is placed here
33.	Status Code	Accretion (initial) record Change or correction including resurvey Delete Terminated

Exhibit E

	Information	Description
34.	Last Transaction Code	-Initial -Resurvey -Correction
35.	Participation Code	-Medicare -Medicaid -Medicare and Medicaid -Non participation
36.	Facility Group	Home Health Agency
37.	Region	HCFA Region
38.	SMSA	Standard Metropolitan Statistical Area
39.	SMSA Size Code	
40.	Run Date of Accretion	Date when initial record entered system
41.	Run Date of Last Transaction	Date last transaction entered system
42.	Change of Ownership Count	Number of times the facility has changed ownership
43.	Resurvey Count	Number of resurveys conducted under present ownership
44.	Prior Owner's Dates	-CHOW -Certification -Termination
45.	Survey Date	Date on site certification survey was conducted
46.	Medicaid-State Vender Number	
47.	Area of Operation	-Less than county wide -Single county -Multi county -Unknown

Exhibit E

Information	Description
48. Number of Employees by Type	
Registered professional nurse	
Licensed practical nurse	
Qualified physical therapist	
Qualified occupational therapist	
Qualified speech pathologist or audiologist	
Home health aides	
Other	
49. Services	Twelve position field Each position coded as follows:
1-Nursing Care	-Provided by staff
2-Physical therapy	-Provided under arrangement
3-Occupational therapy	-Not provided
4-Speech therapy	
5-Medical social services	
6-Home health aide	
7-Interns and residents	
8-Nutritional guidance	
9-Pharmaceutical service	
10-Appliances and equipment service	
11-Vocational guidance	
12-Other	

IV. The Query System - Admission Notices

Introduction

HCFA has the basic responsibility for controlling and monitoring intermediary/carrier payments to beneficiaries or providers. Intermediaries and carriers are responsible for verifying a beneficiary's eligibility, type of coverage, deductible, etc., before a claim is paid. When a beneficiary is hospitalized, the provider notifies the intermediary of the admission, which in turn, transmits the information as a query to HCFA to ascertain the beneficiary's eligibility status. HCFA's query system processes these queries against its' Health Insurance Master file to determine the beneficiary's status. If the beneficiary is covered, HCFA will then prepare an admission notice for in-house subsequent processing and will also transmit a query reply that is used by the intermediary to update its' own history files.

Preparation of the Query Record

A query (admission) record must be submitted by a provider through the intermediary for all Medicare beneficiary admissions including inpatient or skilled nursing facility (SNF) admissions. This is needed by HCFA to maintain accurate benefit period (spell-of illness) information.

The notice of an inpatient hospital admission, when transmitted to HCFA results in recording the beginning of services in the patient's utilization record; i.e., the creation of an "open item". This open item remains on the individual's record until it is closed by a discharge bill. See Exhibit A for contents of the Admission Record.

Queries are also received by HCFA for Supplementary Medical Insurance (SMI) claims. However, after the carrier has verified the beneficiary's entitlement and deductible status, if the deductible is met, subsequent claims are not normally queried. SMI claims involving non-inpatient psychiatric or physical therapy expenses must be queried unless the carrier has information in file from a previous reply indicating that the applicable money limits have been reached. Since current statistics are not being obtained from SMI queries, this manual does not cover those records.

Approximately eleven million admission notice (or query) records are received annually.

Part A (Query) Admission Notice Contents

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Admission Date	Year and Julian date beneficiary admitted as inpatient to hospital or SNF
3.	Query Code	-Initial request -Delete previous request -Follow-up request -Status request
4.	Beneficiary Name a. Surname b. First Initial c. Middle Initial	
5.	Date of Birth	Year and Julian date of beneficiary's birth
6.	Sex	-Male -Female -Unknown
7.	Type of Facility	-Christian Science SNF -Psychiatric -TB -General Care -Regular SNF
8.	Receipt Date	Date admission notice was received into the EDP system

Exhibit A

	Information	Description
9.	Process Date	-Date admission notice was processed
10.	Disposition Code	This code identifies the type of reply made by HCFA to the intermediary. Codes basically indicate approval, rejection, qualified approval, or just an acknowledgement of the receipt of the admission notice.
11.	Reason for Entitlement Trailer Code	-No disability or ESRD involvement -Beneficiary currently insured due to disability. No ESRD involvement -Beneficiary currently insured due solely to ESRD -Beneficiary currently insured for disability with prior or current ESRD involvement -Beneficiary currently insured due to age (OASDI) with prior or current ESRD involvement -Beneficiary currently entitled to Part A coverage due to buy-in provisions with prior or current ESRD involvement
12.	Intermediary Number	Intermediary's identification number
13.	Provider Number	Identification number of the provider submitting the claim

V. Bill Records from Institutional Providers

Introduction

This chapter describes the statistical files created from bills submitted by institutional providers. These are primarily hospitals, skilled nursing facilities, home health agencies, rural health clinics and renal dialysis facilities. They provide Medicare services for both Part A and Part B of the program. They submit their bills to HCFA by way of the Part A intermediary selected by them to process their claims.

One Hundred Percent Files

Provider bills submitted by intermediaries to HCFA enter the statistical system only after they have been updated to the Health Insurance Master Record (HIM). When the bill records are updated to the HIM, the enrollees' demographic characteristics such as age, sex, race and residence are appended. These records, which now contain both billing and demographic information, are cumulated weekly and then entered into the statistical system.

Exhibits A, B and C contain copies of the principal billing forms and their related bill records which comprise the one hundred percent bill files. They are as follows:

Exhibit A - Inpatient Hospital and Skilled Nursing Facility Admission and Billing (Form HCFA-1453). This record contains information from Part A inpatient hospital and inpatient skilled nursing facility bills.

Exhibit B - Home Health Agency Report and Billing (Form HCFA-1487). This record contains Part A and Part B HHA billing information. If a bill contains both Part A and Part B information, two separate tape records are prepared.

Exhibit C - Provider Billing for Medical and Other Health Services (Form HCFA-1483). This record contains Part B outpatient billing information. It is also used for rural health clinic and outpatient renal dialysis services.

The one hundred percent provider bill files, along with the one hundred percent file of payment records, (see Chapter VII), are used to prepare control tables, and a series of monthly, quarterly, semi-annual and annual tabulations. Some tables are based on all of the records and others are based on samples which are inflated. The remaining chapters of this manual describe some of the annual tabulations and the summary records from which they are produced.

Sample Files Containing Diagnostic and Surgical Procedure Codes

In addition to the one hundred percent utilization bill files described above, there are sample files containing diagnostic and surgical procedure codes. These are either coded centrally by HCFA based on the narrative descriptions contained in the various billing forms or reported directly by the intermediary from provider submitted codes. The information on each type of bill is as follows:

Inpatient Hospital - Principal diagnosis and principal surgical procedures (if any) - 20% sample. This was increased to 100% in January 1983.

Inpatient SNF - Admitting diagnosis - 100%

Outpatient Hospital - Nature of illness and surgical procedure (if any) - 5% sample

Home Health Agency - (A or B) - Diagnosis - 40% sample

In all cases, HCFA also codes an indication (yes, no or unknown) of whether additional diagnoses or surgical procedures are indicated on the bill.

Before 1977 most intermediaries submitted hard copy bills to HCFA and coding was done manually. Now all intermediaries send billing and diagnostic-surgical information to HCFA on magnetic tape. For intermediaries reporting narratives, codes are entered into the billing record through a process known as the Automated Medical Coding System (AMCS). This system involves the computer coding of diagnoses and surgical procedures and a clerical procedure for those items not coded by computer. A brief description of how the AMCS works is as follows:

1. Intermediaries key the narrative diagnostic and surgical procedure information along with all of the other billing items. Up to 45 characters are keyed for diagnosis and 41 for surgery. This Bill Record is submitted to HCFA on magnetic tape.

2. The keyed narrative (available on sample bills only) is split off by HCFA along with identifying information to allow it to be matched back to the proper Bill Record. This new record, called the Coding Record, is processed through the AMCS.

3. The Coding Record is matched to a dictionary which contains diagnostic terms and their codes. When there is a match, the code from the dictionary is applied to the Coding Record. This record is later matched back to the bill and the code entered into the Bill Record. When there is no match, a proposed code is assigned and the list of narratives and their proposed codes are sent to trained coders. The coders either accept the proposed code or enter the correct code next to it. These items are then keyed with the correct code and identifying information and matched back to the Bill Record.

4. Periodically, the dictionary is updated.

5. For diagnoses, ICD-9-CM Volumes 1 and 2 codes are used.

6. For surgical procedures, the identical process is used. The codes are ICD-9-CM Volume 3.

Beginning 1981, providers were permitted, with the intermediaries' concurrence, to report codes instead of narratives. These codes must be the full ICD-9-CM codes and the intermediary must transmit to HCFA the original codes reported. Otherwise, the intermediary must transmit the original narratives as reported by the provider to HCFA.

Beginning October 1983, inpatient hospitals were required to report ICD-9-CM codes only. Narratives were no longer permitted. Hospitals are required to report codes for the principal diagnosis and up to four additional diagnoses and the principal surgical procedure and up to two additional surgical procedures, if any. Inpatient hospital bills also contain a Diagnosis Related Group (DRG) number used to determine reimbursement for prospective payment. Medicare bills other than inpatient hospital can still be reported using either narratives or codes.

Annual Volume of Records for the One Hundred Percent Files - 1982

1. Inpatient Bills - 12 Million

2. Home Health Agency Bills - 3.8 Million

3. Outpatient Bills - 26 Million

4. Skilled Nursing Facility Bills - 1 Million

These bill records along with approximately 150 million Part B Payment Records are on monthly files based on month processed in HCFA. Each monthly file contains all types of bills in sequence by Health Insurance Claim Number and comprises approximately 85 reels of magnetic tape.

INPATIENT HOSPITAL AND SKILLED NURSING FACILITY ADMISSION AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS-SOCIAL SECURITY ACT

Form Approved
OMB No. 0938-R0014

This report is authorized by 42 USC 1395f, 42 CFR 405.1660. Your cooperation is needed to keep proper beneficiary records and to make proper Medicare payments.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1 Patient's last name	First name	MI	2 Sex ☐M ☐F	3 Health insurance claim number
4 Patient's address (Street number, City, State)		Zip Code	5 Date of birth	6 Medical record number
7 Date of this admission	8 Provider name and address (City and State)		9 Provider number	10 Attending physician
11 Dates of qualifying stay: FROM / THRU	12 Qualifying and other prior stay information			

If any of your medical expenses may be paid by your insurance organization or State Agency, complete items 13 and 14. If you do not want information about this Medicare claim released to your insurance organization, check this block ☐

13 Name and address of organization or agency	14 Policy or Identification Number

15 Patient's Certification, Authorization to Release Information, and Payment Request: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signature (Patient or authorized representative) (Signature by mark must be witnessed)	☐ Contained in provider's record	Date

16 Admitting diagnoses	Employment Related and/or Entitlement to Other Government Programs ☐Yes ☐No (If Yes, Give Name and Address of Employer and/or Program)	Do not use this space
17 (a) Principal diagnosis	(b) Other diagnoses	
18 Surgical procedures (Show date of each)		

19 STATEMENT OF SERVICES RENDERED

	Blood pints furnished	Pints replaced	Not replaced	Charge per pint	Total Charges	Non-Covered Chgs
A						

	Accommodation	Days	Rate		
B	1-Bed				
C	2-3-4 Bed				
D	5 or more Beds				
FOR HOSPITAL	E Intensive care				
	F Coronary care				
	G				
	H Operating room				
	I Anesthesia				
OMIT	J Outpatient services				
	K Blood administration				
	L Pharmacy				
	M Radiology				
	N Laboratory				
	O Medical, surgical and central supplies				
	P Physical therapy				
	Q Occupational therapy				
	R Speech pathology				
	S Inhalation therapy				
	T Other (Describe)				
	U TOTALS				
	V Inpatient deductible				
	W Blood deductible pts @				
	X Coinsurance days ( ) ( )				
	Y TOTAL DEDUCTIONS				

20 Statement covers period FROM / THRU	
21 Date guarantee of payment began	22 Date UR notice received
23 Date active care ended	24 Date benefits exhausted
25 Patient status: A Date discharged / B Date of death / C ☐ Still patient	
26 Lifetime reserve days	27 Non-covered days / 28 Covered days
30 Remarks	
PIP (a) ☐	
31 Reimbursement amount $	
FOR INTERMEDIARY USE: From / Thru / 33 Non-134 Days pmt code used	

29 I certify that the required physician's certification and recertifications are on file

Signature of provider representative	Date Received	35 Approved by	Date approved

Form HCFA-1453 (1-80) (Formerly SSA-1453 (6))

Department of Health, Education and Welfare
Health Care Financing Administration

Exhibit A

Inpatient Hospital and SNF Bill Records

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Record Identification Code	Part A, HCFA-1453 bill
3.	Bill Covers Period	Statement Covers Period Form HCFA-1453, Item 20, Year and Julian date.
	a. From Date	Beginning date of bill
	b. Thru Date	Ending date of bill
4.	Query Code	Code indicating status of bill -Credit adjustment -Interim Bill -Final Bill -Discharge Bill -Discharge notice -Debit adjustment
5.	Bill Form	Type of bill -Form HCFA-1453 (Inpatient, SNF) -Form HCFA-1486 (Christian Science) -Non Payment bills for Forms HCFA-1453 and HCFA-1486
6.	Transaction Code	Type of Facility -Christian Science SNF -Psychiatric hospital facility -Tuberculosis hospital facility -General Care hospital facility -Regular SNF

Exhibit A

Information	Description
7. Transaction Type	Indication of Special types of bills -Special 143 (a) bills -PIP bills -Section 144 (a) bills -Discharge notice -None of the above
8. Medicare Status Code	Coded to show the reason for beneficiary's entitlement to Medicare benefits -Aged only - no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9. Beneficiary's Name	
a. Surname	
b. Initial- 1st	
c. Initial- 2nd	
10. State-County Code	SSA geographic code book, Publication 026
11. Date of Birth	Year and Julian date of beneficiary's birth
12. Sex	Sex code obtained from HI Master Record -Male -Female -Unknown

Exhibit A

	Information	Description
13.	Race	Race code obtained from HI Master Record -White -Black -Other -Unknown
14.	Zip Code of residence	
15.	Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number
16.	Medicare Provider Number	Provider number shown on HCFA-1453, Item 9
17.	Intermediary Number	Identification number of the intermediary processing the bill
18.	Batch Number a-Sequence	Control number assigned to batch by the intermediary
	b-Date	Julian date batched by intermediary
19.	Sequence Number	Sequence number assigned to bill -01-55 Initial bills -77 Adjustment bills -88 Over 55 bills to a batch -99 Incomplete bill
20.	Adjustment Code	Code indicating a Cancel Only bill -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other

Exhibit A

Information	Description
21. Data Indicators	Information relating to various possible conditions contain a code indicating the presence, absence, or combination of those conditions that exist
a-Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
b-Current Reason for Entitlement	-OASI -DIB -Renal
c-Original Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
d-HMO Indicator	-HMO involvement -No HMO involvement
e-End Stage Renal Disease Indication	Coded to indicate method of original notice of ESRD -No ESRD -MBR notice of ESRD -HI notice of ESRD -NIH notice of ESRD -MBR-HI notice of ESRD -MBR-NIH notice of ESRD -HI/NIH notice of ESRD -MBR/HI/NIH notice of ESRD
f-Uniform Bill	-Yes -No

Exhibit A

	Information	Description
22.	Date Approved	Year and Julian date bill approved by Intermediary. Form HCFA-1453, Item 35
23.	Date Forwarded	Year and Julian date bill received by Intermediary. Form HCFA-1453, Item 29
24.	Total Charges	Total charges for all accommodations and services. Form HCFA-1453, Item 19U
25.	Reimbursement Amount	Reimbursement amount for bill. Form HCFA-1453, Item 31 The reimbursement amounts shown are interim payments made to the hospital. Final reimbursement is made on a cost basis based on the cost report each hospital is required to prepare at the end of their fiscal year. Beginning October 1983, for most hospitals, this amount will be based on the DRG.
26.	Diagnosis Data	Only present on 20% sample bills. Form HCFA-1453, Item 7.
	a-Principal Diagnosis Code	Coding Based on ICD-9-CM, Volumes 1 and 2
	b-Additional Diagnosis Indicator	-No additional diagnosis -Additional diagnosis -Additional diagnosis unknown

NOTE: Beginning October 1983 this field will contain codes for up to four additional diagnoses.

	c-Source of Coding	Indicates where the diagnosis was coded -Provider -HCFA

NOTE: For SNF bills Item 26 is used for admitting diagnosis and is coded on 100% of the bills.

Exhibit A

Information	Description
27. Surgery Data	Form HCFA-1453, Item 18
a-Principal Surgery	Coding based on ICD-9-CM, Volume 3
b-Additional Surgery Indicator	-No additional surgery -Additional surgery -Additional surgery unknown

NOTE: Beginning October 1983 this field will contain codes for up to two additional surgical procedures.

c-Source of Coding	Indicates where the surgery was coded -Provider -HCFA
d-Date of Surgery	Year and Julian date on which principal surgery was performed
28. Date of Admission	Year and Julian date of beneficiary's admission to hospital. Form HCFA-1453, Item 7
29. Qualifying Dates	Year and Julian date of qualifying stay for SNF. Form HCFA-1453, Item 11
a-From Date	Beginning date of stay
b-To Date	Ending date of stay
30. Patient Status	Form HCFA-1453, Item 25
a-Discharge Code	-Discharged (alive) -Died -Still patient
b-Discharge Date	Year and Julian date patient was discharged
c-Discharge Destination (beginning October 1983)	-Home -Another hospital -SNF -ICF -Another institution -Home health care -Left against medical advice

Exhibit A

Information	Description
31. Non-Payment Code	Reason for non-payment, Form HCFA-1453, Item 33 -Covered Workmen's Compensation -Benefits Exhausted -Custodial Care -Non-covered -Payment Refused -Workmen's Compensation
32. Non-Covered Days	Form HCFA-1453, Item 27
33. Lifetime Reserve Days Used	Form HCFA-1453, Item 26
34. Covered Days	Form HCFA-1453, Item 28
35. Accommodations	Data obtained from Form HCFA-1453, Item 19 B-F The information below is shown for each of the possible 5 types of accommodations: 19B - 1 bed 19C - 2, 3, 4 beds 19D - 5 or more beds 19E - Intensive care 19F - Coronary care
a-Code	Indicates appropriate entry from line 19 (constant codes B-F)
b-Number of days c-Charges d-Non-Covered charges	
36. Blood usage	Obtained from Form HCFA-1453, Item 19A
a-Code b-Furnished c-Replaced d-Not Replaced e-Charge Per Pint f-Total Charge g-Non-Covered Charge	Constant A

Information	Description
37. Service usage	Data obtained from Form HCFA-1453, Item 19H-T. The information below is shown for each of the 13 types of services: H-Operating room I-Anesthesia J-Outpatient K-Blood L-Pharmacy M-Radiology N-Laboratory O-Supplies P-Physical Therapy Q-Occupational Therapy R-Speech Pathology S-Inhalation Therapy T-Other
a-Code	Indicates appropriate entry from Item 19. (Constant H-T)
b-Total Charges c-Non-Covered Charges	
38. Non-Covered Charges	Non-covered charges for all Ancillaries, Form HCFA-1453, Item 19U
39. Inpatient Deductible	Deductible to be paid by beneficiary. Form HCFA-1453, Item 19V
40. Blood Deductible	Obtained from Form HCFA-1453, Item 19W
a-Pints b-Charge Per Pint c-Amount of Blood Deductible	

Exhibit A

	Information	Description
41.	Coinsurance Days and Amount	Obtained from Form HCFA-1453, Item 19X
	a-Days b-Rate per day c-Total Amount	
42.	Total Deductions	Obtained from Form HCFA-1453,Item Y. Represents total non-covered charges, total deductibles and coinsurance amounts.
43.	Guarantee of Payment Date	Year and Julian date Guarantee of payment began. Form HCFA-1453, Item 21
44.	UR Date	Year and Julian date Utilization Review notice received, Form HCFA-1453, Item 22
45.	Date Active Care Ended	Year and Julian date active care ended. Obtained from Form HCFA-1453, Item 23
46.	Date Benefits Exhausted	Year and Julian date benefits were exhausted. Obtained from Form HCFA-1453, Item 24
47.	Verified Non-Covered Stay Dates	Year and Julian dates covering a verified non-covered stay. Obtained from Form HCFA-1453, Item 32
	a-From Date	Beginning date of stay
	b-Thru Date	Ending date of stay
48.	DRG Number	Diagnosis Related Group. This item available for all inpatient hospital bills beginning October 1983.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

EXHIBIT B

Form Approved
OMB No. 066-R0016

HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER

3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)	4. DATE OF BIRTH	5. SEX
		☐ M ☐ F

6. HOME HEALTH AGENCY NAME AND ADDRESS	7. PROVIDER NO.	9. NAME AND ADDRESS OF ATTENDING PHYSICIAN
	8. MEDICAL RECORD NO.	

10. DATE CARE STARTED	11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES	12. VERIFIED DATES OF STAY IN ITEM 11 FROM / TO	13. DATE HOME HEALTH PLAN ESTABLISHED

14. PAYMENT SOURCE FOR CHARGES TO PATIENT

A. ☐ SELF OR FAMILY C. ☐ BLUE CROSS BLUE SHIELD E. ☐ PUBLIC AGENCY (Give name)
B. ☐ PRIVATE INSURANCE D. ☐ EMPLOYER OR UNION F. ☐ OTHER (Explain)

15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)	DATE

16. DIAGNOSES	EMPLOYMENT RELATED		LEAVE BLANK
	A. ☐ YES B. ☐ NO	(If yes, give name and address of employer.)	

17. STATEMENT COVERS PERIOD FROM	TO	18. DATE OF FIRST VISIT	DATE OF LAST VISIT	19. PATIENT ☐ DISCHARGED ☐ STILL RECEIVES SERVICES ☐ DIED ☐ VISITS EXHAUSTED	20. DATE APPLICABLE TO ITEM 19

21. STATEMENT OF SERVICES RENDERED	POST - HOSPITAL PLAN NO. VISITS	POST - HOSPITAL PLAN CHARGES	MEDICAL PLAN NO. VISITS	MEDICAL PLAN CHARGES
PRIMARY PURPOSE OF VISIT				
A. Skilled Nursing Care		$		$
B. Physical Therapy				
C. Speech Therapy				
D. Occupational Therapy				
E. Medical Social Services				
F. Home Health Aide				
G. Other Visits (Specify)				
H. Total No. of Units of Service				
I. Charge per unit of Service $				
J. TOTALS		$		$
K. Other (Specify)				
L. TOTAL CHARGES		$		$
M. AMOUNT PAID BY PATIENT				$

22. POST - HOSPITAL PLAN	23. MEDICAL PLAN
A. TOTAL CHARGES	A. VERIFIED DEDUCTIBLE
B. REIMBURSEMENT RATE	B. VERIFIED COINSURANCE
C. REIMBURSEMENT AMT. A TIMES B	C. TOTAL CHARGES
	D. REIMBURSEMENT RATE
	E. C TIMES D
	F. E LESS A
	G. REIMBURSEMENT AMT. 80% OF F
	H. REFUND TO PATIENT
	I. NET AMOUNT TO AGENCY, G LESS H

I certify that required physician's certification and recertifications are on file.

SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE	DATE FORWARDED	APPROVED BY	DATE APPROVED

Exhibit B

Home Health Agency Bill Record

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Record Identification Code	-Home Health Part A -Home Health Part B
3.	Statement Covers Period	Data obtained from Form HCFA-1487, Item 17
	a-Bill-From-Date	-Year and Julian beginning date of bill
	b-Bill-Thru-Date	-Year and Julian ending date of bill
4.	Medicare Status Code	-Aged only, no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
5.	Beneficiary's Name	
	a-Surname b-First Initial c-Middle Inital	
6.	State and County Code of Residence	SSA geographic code book, Publication 026
	a-State Code b-County Code	
7.	Date of Birth	Year and Julian date of beneficiary's birth
8.	Sex	Sex code from HI Master Record -Male -Female -Unknown

Exhibit B

	Information	Description
9.	Race	-White -Black -Other -Unknown
10.	ZIP Code of Residence	Actual
11.	Medicare Provider Number	Provider number on bill-Form HCFA-1487, Item 7
12.	Intermediary Number	Identification number of intermediary processing bill
13.	Data Indicators	Information, relating to various possible conditions,contains a code indicating the presence, absence or combination of those conditions that exist
	a-Employment Related	-None -Complementary insurance -Employment related -Both conditions present
	b-Current Reason for Entitlement	-OASI -DIB -Renal -DIB and Renal
	c-Original Reason for Entitlement	-OASI -DIB -Renal
	d-End Stage Renal Disease Indication	-MBR notice of ESRD -HI notice of ESRD -NIH notice of ESRD -MBR/HI notice of ESRD -MBR/NIH notice of ESRD -HI/NIH notice of ESRD -MBR/HI/NIH notice of ESRD

Exhibit B

	Information	Description
14.	Date Approved	Year and Julian date bill approved by intermediary
15.	Date Forwarded	Year and Julian date bill received by intermediary
16.	Total Charges	Total charges for all services. Form HCFA-1487, Item 21L
17.	Reimbursement Amount	Total interim reimbursement amount for bill. Form HCFA-1487, Item 22C if HI usage, Item 23G if SMI.
18.	Diagnosis Data	Only present on 40% sample bills
	a-Diagnostic Code	ICD-9-CM, Volumes 1 and 2
	b-Additional Diagnosis Indicator	-No additional diagnosis -Additional diagnosis -Additional diagnosis unknown
	c-Source Code	Indicates where the diagnosis was coded -Provider -HCFA
19.	Date of Admission	Year and Julian date care began. Form HCFA-1487, Item 10
20	Patient Status	Form HCFA-1487, Item 19
	a-Discharge Code	-Discharged -Died -Still patient
	b-Discharge Date	Year and Julian date applicable to patient status. Form HCFA-1487, Item 20

Exhibit B

	Information	Description
21.	Plan Date	Year and Julian date plan was established, Form HCFA-1487, Item 13
22.	Service Visits	Data obtained from Form HCFA-1487, Items 21A through 21G2. The information below is shown for each of the possible 8 types of service visits: -Skilled Nursing Care -Physical Therapy -Speech Therapy -Occupational Therapy -Medical Social Services -Home Health Aide -Other -Additional Other
	a-Code for Service	Indicates appropriate entry from Item 21 (Constant A through G2)
	b-Number of Visits	
	c-Charges	
23.	Total	
	a-Code J	Constant J
	b-Visits	Total number of visits for all services A through G
	c-Charges	Total visit charges for all services A through G
24.	Other Services	Data obtained from Form HCFA-1487, Item 21K. The information below is shown for each of the possible 4 lines of other services: -First other -Second other -Third other -Fourth other
	a-Code for Service	Indicates appropriate entry from Item 21K
	b-Charges	

EXHIBIT C

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES

Form Approved
OMB No. 0938-0008

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

This report is authorized by 42 USC 1395u 42 CFR 405 1660. Your cooperation is needed to keep proper Beneficiary Records and to make proper Medicare Payments.
NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name	First name	MI	2. Health insurance claim number
3. Patient's address (Street number, City, State)		Zip Code	4. Date of birth / 5. Sex ☐ M ☐ F
6. Provider name and address (City and State)	7. Provider number		9. Type of service: A. ☐ Inpatient B. ☐ Outpatient C. ☐ Other (Specify)
	8. Medical record number		

If any of your medical expenses may be paid by your insurance organization or State Agency, complete items 10 and 11. If you do not want information about this Medicare claim released to your insurance organization, check this block ☐

10. Name and address of organization or agency	11. Policy or identification number

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signature (Patient or authorized representative) (Signature by mark must be witnessed)	☐ Contained in provider's record	Date

13. Nature of illness or injury — Employment Related and/or Entitlement to Other Government Programs ☐ Yes ☐ No (If Yes, Give Name and Address of Employer and/or Program)

Do not use this space

14. Surgical procedures

15. Statement of services	Covered Charges		16. Statement Covers Period	First service	Last service
A. Clinic visit ( )					
B. Emergency room ( )			17. Blood Information	A. Pints furnished / B. Pints replaced / Not Replaced: C. Pints / D. Charge per pint / E. Patient paid for deductible	
C. Laboratory					
D. Radiology			18. Professional component (hospital inpatients)		19. Other professional component
E. Pharmacy			A. Pathology	B. Radiology	
F. Blood			20. Date benefits exhausted or HM plan terminated		21. Patient paid (Excluding 17E)
G. Ambulance			22. I certify that the required physician's certification is on file.		23. Date received
H. Physical therapy			FOR INTERMEDIARY USE ONLY		
I. Other (Specify)			24. Verified Patient Liability		
			A. Blood deductible	B. Cash deductible	C. Coinsurance
			25. Payment Distribution		26. Date approved
J. TOTAL			Provider	Patient	

Remarks:

Form HCFA-1483 (1-80) (Formerly SSA-1483)

Department of Health, Education and Welfare
Health Care Financing Administration

Exhibit C

Outpatient Bill Record

Information	Description
1. HI Claim Number	Beneficiary's Health Insurance claim number
2. Statement Covers Period	Year and Julian date obtained from Form HCFA-1483, Item 16
a-First Service	Date of first service
b-Last Service	Date of last service
3. Transaction Type	Type of facility
	-Outpatient Psychiatric hospital -Outpatient Tuberculosis hospital -Outpatient General Care hospital -Outpatient SNF -Home Health Agency -Clinic Rehabilitation Agency -Other -Psychiatric Hospital Facility -Tuberculosis Hospital Facility -General Care Hospital Facility -Regular SNF
4. Medicare Status Code	Coded to show the reason for beneficiary's entitlement to Medicare benefits
	-Aged only, no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Exhibit C

	Information	Description
5.	Beneficiary's Name a-Surname b-Initial-1st c-Initial-2nd	
6.	State and County Code	SSA geographic codes obtained from HI Master Record indicating State and county of beneficiary's residence
7.	Date of Birth	Year and Julian date of beneficiary's birth
8.	Sex	-Male -Female -Unknown
9.	Race	-White -Black -Other -Unknown
10.	ZIP code	Actual
11.	Medicare Provider Number	Provider number shown on Form HCFA-1483, Item 7
12.	Intermediary Number	Identification number of the intermediary processing the bill

Exhibit C

	Information	Description
13.	Date Approved	Year and Julian date bill approved by intermediary, Form HCFA-1483, Item 26
14.	Date Forwarded	Year and Julian date bill received by intermediary, Form HCFA-1483, Item 23
15.	Total Charges	Total charges for all services, Form HCFA-1483, Item 15J
16.	Reimbursement Amount	Sum of amounts shown in payment distribution (provider amount plus patient amount), Form HCFA-1483, Item 25.
17.	Diagnosis Data	Obtained on 5% sample bills only
	a-Diagnostic Code	Nature of illness, obtained from Form HCFA-1483, Item 13 coded based on ICD-9-CM, Volumes 1 and 2
	b-Additional Diagnosis Indicator	-No additional diagnosis -Additional diagnosis -Additional diagnosis unknown
	c-Source of Coding	Indicates where the diagnosis was coded -Provider -HCFA
18.	Surgery Data	Obtained on 5% sample bills only
	a-Surgery Code	Code indicating type of surgery performed. Form HCFA-1483, Item 14, ICD-9-CM, Volume 3

Exhibit C

	Information	Description
18.		
	b-Additional Surgery Indicator	-No additionsl surgery -Additional surgery -Unknown
	c-Source of Coding	Indicates where the surgery was coded -Provider -HCFA
	d-Date of Surgery	Year and Julian date on which the surgery was performed
19.	Clinic Services	Data obtained from Form HCFA-1483, Item 15A
	a-Service Code b-Number of Visits c-Covered Charges	Constant A
20.	Emergency Room Services	Data obtained from Form HCFA-1483, Item 15B
	a-Service Code b-Number of Visits c-Covered Charges	Constant B
21.	Other Services	Data obtained from Form 1483, Item 15C-I The information below is shown for each of the 7 remaining types of services: C-Laboratory D-Radiology E-Pharmacy F-Blood G-Ambulance H-Physical therapy I-Other
	a-Service Code	Indicates the appropriate entry from Form HCFA-1483, Item 15 (Constant C-I)
	b-Covered Charges	

Exhibit C

Information	Description
22. Blood Information	Obtained from Form HCFA-1483, Item 17A-E
a-Pints Furnished	Whole and half pints
b-Pints Replaced	Whole and half pints
c-Pints Not Replaced	Whole and half pints
d-Charge Per Pint	
e-Patient Paid for Deductible	Cost to beneficiary for blood not replaced
23. Professional Components	Amounts for hospital inpatients. Obtained from Form HCFA-1483, Item 18A&B and Item 19 NOTE: This item filled in only if physician bills separately
a-Pathology	
b-Radiology	
c-Other	
24. Date Benefits Terminated	Year and Julian date benefits were exhausted or HH Plan was terminated. Form HCFA-1483, Item 20
25. Patient Paid	Amount paid by patient excluding blood deductible. Obtained from Form HCFA-1483, Item 21
26. Verified Patient Liability	Amount of patient's liability. Obtained from Form HCFA-1483, Item 24 A-C.
a-Blood Deductible	
b-Cash Deductible	
c-Coinsurance	
27. Payment Distribution	
a-Provider	
b-Patient	

VI. Stay Records

Introduction

The Inpatient Hospital Stay Record contains information about a person's stay in a hospital from admission through discharge for a 20 percent sample of Medicare enrollees. Stay records are used to compile a very large portion of the health insurance utilization statistics such as the annual short-stay hospital tabulations, current utilization tabulations, and Medicare Provider Analysis and Review (MEDPAR) files. This record contains utilization information from bills, demographic information about the enrollee, and provider information. The 20 percent sample file contains about 2,000,000 records per year.

Billing and Demographic Information

The basic input for the hospital stay records are bills for inpatient hospital services submitted to HCFA via intermediaries for Medicare payments by hospitals. Bills which have cleared the administrative process at HCFA and have been updated to the Health Insurance Master File (HIMA) are entered into the statistical system. When the bill record is updated to the HIMA, the enrollee's demographic characteristics such as age, sex, race, and State and county of residence are appended to it. The record sent for statistical processing contains both the billing information and a person's demographic characteristics. Chapter V describes the contents of these records. For the hospital stay record operations, only a 20 percent sample of hospital bills is used.

All bills submitted for the same hospital stay are sorted and summarized, creating a bill summary record. When the bill summary indicates that the patient has been discharged (i.e., a discharge bill has been received), a stay record showing information from date of admission to date of discharge is created. A single bill, in approximately 95% of all cases, will result in a completed stay record. If the patient has not been discharged, the bill summary remains on an orbiting bill summary file until the discharge information is received.

Bills used for creating stay records contain a principal diagnosis code and an indication of whether or not there were additional diagnoses. The five digit diagnostic code is assigned from the ICD-9-CM Volumes I and II. If surgery has been performed, a principal surgical procedure code, an indication of additional surgical procedures, and a date of surgery are also shown on the bill. The four digit surgical procedure code is assigned from the ICD-9-CM Volume III. Beginning in 1984, codes for up to four additional diagnoses and up to two additional surgical procedures will be shown. There will also be a Diagnosis Related Group (DRG) number included beginning in 1984.

Provider Information

Periodically, stay records are matched to the Provider of Services file to append selected provider information to the stay records. This file contains detailed information about the characteristics of each hospital participating in the Medicare program. Some of these characteristics are: location of the hospital; type of hospital; type of control and bed size. Chapter III of this manual contains a description of the Provider of Services Master File.

SNF Stay Records

Stay records are also prepared for stays in Skilled Nursing Facilities. The SNF stay record is essentially the same as the hospital record except that instead of a 20 percent file, a 100 percent file is created. This is because of the small volume (approximately 400,000 per year). SNF stay records contain an admitting diagnosis instead of the principal diagnosis, and there is no surgery. The five digit admitting diagnosis code is assigned from the ICD-9-CM, Volumes I and II as is the inpatient hospital bill principal diagnosis. There are also dates of admission and discharge of the qualifying hospital stay.

Derivative Files

Exhibit A contains the contents of the 20 percent sample inpatient hospital stay record. Approximately 2.0 million records are included in this annual file. Exhibit B contains the contents of the MEDPAR (Medicare Provider Analysis and Review) record. The MEDPAR record is derived from the inpatient hospital stay record and the Provider of Services File, from which provider characteristics are appended to the stay record. Each record contains selected items of information from the hospital stay record. The file of MEDPAR records is prepared every 6 months and contains 3 years of discharges, the current year and 2 previous years. For example, the file created at the end of December 1982 contains discharges from 1980 through 1982. Annually, approximately 2.0 million records are created.

Exhibit C contains the contents of the MEDPAR Public Use File. This file (produced for 1980 discharges and afterwards) contains selected data fields extracted from the MEDPAR records. Personal identifiers are omitted to enable use for non-HCFA purposes.

Exhibit D contains the contents of the Skilled Nursing Facility (SNF) stay record.

Exhibit E contains the contents of a skeleton SNF stay record which is produced annually with a 1 year lag. This file is based on admissions (not discharges) because there are many long SNF stays where the final discharge bill does not come in until long after SNF benefits have been exhausted. Approximately 400,000 records are included in the annual file.

Exhibit A

Inpatient Hospital Stay Record - 20% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Transaction Code	-Psychiatric hospital -Tuberculosis hospital -General Care hospital
3.	Date of Birth	Year and Julian date of beneficiary's birth
4.	Sex	-Male -Female -Unknown
5.	Race	-White -Black -Other -Unknown
6.	State-County Code	SSA geographic codes obtained from HI Master Record indicating State and county of beneficiary's residence
7.	Dual Entitlement to SSA and RRB benefits	-No -Yes
8.	State Buy-In	-No -Yes
9.	Cross-Reference Account Number	Beneficiary's cross-reference claim number
10.	Medicare Provider Number	Identification number of the provider submitting the claim
11.	Admission Date	Year and Julian date the beneficiary entered the care of the provider
12.	Discharge Date	Year and Julian date the beneficiary left the care of the provider or died
13.	Discharge Status	-Discharged Alive -Died

Exhibit A

Information	Description
13a. Discharge Destination (Beginning 1984)	-Home -Another hospital -SNF -ICF -Another institution -Home health care -Left against medical advice
14. Principal Diagnosis Code	Code from the discharge bill indicating the principal diagnosis. ICD-9-CM Volumes I&II
a-Source of Coding	Indicates where the diagnosis was coded -Provider -HCFA (Central Office)
15. Additional Diagnoses	-Had no additional diagnoses -Had at least one additional diagnosis -Unknown

NOTE: Beginning 1984 this field will contain codes for up to four additional diagnoses.

16. Surgery Indication	-Had no surgery -Had surgery
17. Principal Surgery Code	Code indicating the type of surgery performed, if any. ICD-9-CM Volume III
a-Source of Coding	Indicates where the surgery was coded -Provider -HCFA (Central Office)
18. Additional Surgical Procedures	-Had no additional surgery -Had additional surgery -Unknown

NOTE: Beginning 1984 this field will contain codes for up to two additional surgical procedures.

Exhibit A

	Information	Description
19.	Age at Admission	Beneficiary's age as of last birthday at date of admission
20.	Intermediary Number	Identification number of intermediary processing the claim
21.	Date of Surgery	Year and Julian date surgery performed
22.	Billing Dates From-To	Year and Julian dates from final bill
23.	Guarantee of Payment Date	Year and Julian last day the provider is guaranteed payment for services of an uncertified beneficiary
24.	Utilization Review Date	Year and Julian date review of the patient's need for continued hospitalization
25.	Date Active Care Ended	Year and Julian date the active care ended. (TB and Psychiatric stays only)
26.	Date Benefits Exhausted	Year and Julian date Medicare coverage was exhausted
27.	Forwarding Date	Year and Julian date the final bill was forwarded by hospital
28.	Approval Date	Year and Julian date the final bill was approved by the intermediary

Exhibit A

	Information	Description
29.	Estimated Total Charge Indicator	Indicates that total charge field is estimated (not actual)
30.	Number of Bills Used for this Stay	Total number of bills used to create stay
31.	Type of Bills Used	Initial debit bills only
32.	Date Stay Created	Date stay record produced
33.	Total Charges	Amount of the total of all expenses in this stay
34.	Non-Covered Charges	Amount of the total non-reimbursable expenses
35.	Reimbursement	The reimbursement amounts shown are interim payments made to the hospital. Final reimbursement is made on a cost basis based on the cost report each hospital is required to prepare at the end of it's fiscal year. Beginning 1984,for most hospitals, this amount will be based on the DRG.
36.	Not Reimbursed	Amount of the difference between the total charges and reimbursement amount
37.	Coinsurance Amount	Amount of the coinsurance incurred in this stay
38.	Inpatient deductible	Amount of deductible expense incurred in this stay
39.	Length of Stay	Total length of the hospital stay. Date of admission through date of discharge.

	Information	Description
40.	Covered Days	Number of covered days in the stay
41.	Lifetime Reserve Days Used	Lifetime reserve days used in stay
42.	Coinsurance Days	Coinsurance days used in stay
43.	Accommodation Days	Sum of all accommodation days used in stay
44.	Accommodations Total Charges	Amount of the total charges fields from all the accommodations
45.	First Accommodations	Type of Accommodation -1 bed facility -2-4 bed facility -5 or more bed facility -Intensive Care -Coronary Care
	a-Number of Days	Number of days in stay
	b-Total Charges	Total charges for this accommodation
	c-Covered Charges	Covered charges for this accommodation. The above information is shown for each of the possible 5 types of accommodation.
46.	Departmental Charges	Total whole dollar amount for services and related charges

Information	Description
47. Services Used	Type of Service Used Operating room Pharmacy Laboratory Radiology Medical, Surgical and Central Supplies Anesthesia Inhalation Therapy Other Services Physical Therapy Occupational Therapy Speech Therapy Outpatient Services Blood Administration
a. Total Charges	Total charges for this service
b. Covered Charges	Covered charges for this service
	The above information is shown for each of the possible 13 types of service
48. Blood Pints Used	Number of whole pints used
49. Blood Pints Replaced	Number of whole pints replaced
50. Blood Pints not Replaced	Number of whole pints not replaced
51. Blood Deductible Pints	Number of whole pints of blood used in this stay credited toward deductible amounts
52. Blood Total Charges	Amount of total charges for blood used

Exhibit A

	Information	Description
53.	Blood Total Covered Charges	Amount of covered charges for blood used
54.	Blood Deductible Amount	Amount of the blood used toward the deductible amount
55.	Medicare Status Code	-Aged -Aged with End Stage Renal Disease -Disabled -Disabled with End Stage Renal Disease -End Stage Renal Disease Only
56.	Original Reason for Entitlement (OREC)	-OASI -DIB -Renal -Renal and DIB
57.	Current Reason for Entitlement (CREC)	-OASI -DIB -Renal
58.	End Stage Renal Disease Indication	Coded to indicate method of original notice of ESRD -MBR Notice of ESRD -HI Notice of ESRD -NIH Notice of ESRD -MBR/HI Notice of ESRD -MBR/NIH Notice of ESRD -HI/NIH Notice of ESRD -MBR/HI/NIH Notice of ESRD
59.	ZIP Code of Residence	Actual
60.	DRG Number	Diagnosis Related Group (Beginning 1984)

Exhibit B

MEDPAR Record Description - 20% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Age	Age as of last birthday on date of admission
3.	Sex	-Male -Female -Unknown
4.	Race	-White -Black -Other -Unknown
5.	Medicare Status Code	-Aged -Aged with End Stage Renal Disease -Disabled -Disabled with End Stage Renal Disease -End Stage Renal Disease Only
6.	Beneficiary's State and County Code of Residence	SSA Geographic code book Publication 026
7.	ZIP Code of Residence	Actual
8.	Day of Admission	Sunday Monday Tuesday Wednesday Thursday Friday Saturday
9.	Discharge Status	-Discharged alive -Dead
9a.	Discharge Destination (Beginning 1984)	-Home -Another hospital -SNF -ICF -Another institution -Home health care -Left against medical advice

Exhibit B

	Information	Description
10.	PSRO of provider (Professional Standards Review Organization)	Actual number
11.	Medicare Provider Number	Identification number of the provider submitting the claim
12.	Date of Admission	Year and Julian date beneficiary was admitted to provider's care
13.	Date of Discharge	Year and Julian date beneficiary left the provider's care or died
14.	Length of Stay	Total length of the hospital stay. Date of admission through date of discharge.
15.	Covered Days	Number of covered days in the stay
16.	Coinsurance Days	Coinsurance days used in the stay
17.	Lifetime Reserve Days	Lifetime reserve days used in the stay
18.	Total Charges	Total amount of all expenses in this stay
19.	Covered Charges	Amount of covered charges in this stay

Exhibit B

	Information	Description
20.	Amount Reimbursed	Amount of reimbursement for this stay. The reimbursement amounts shown are interim payments made to the hospital. Final reimbursement is made on a cost basis based on the cost report each hospital is required to prepare at the end of their fiscal year. Beginning 1984, for most hospitals, this amount will be based on the DRG.
21.	Intensive Care and Coronary Care Days	Total days obtained from HCFA-1453, Lines 19E and 19F
22.	Total Accommodation Charges	Total amount of all accommodation charges obtained from HCFA-1453, Lines 19B, 19C and 19D
23.	Total Departmental (Ancillary) Charges	Total amount of all ancillary charges obtained from HCFA-1453, sum of Lines 19H through 19T
24.	Intensive Care and Coronary Care Charges	Total charges obtained from HCFA-1453, Lines 19E and 19F
25.	Operating Room Charges	Charges obtained from HCFA-1453, Line 19H
26.	Pharmacy Charges	Charges obtained from HCFA-1453, Line 19L
27.	Laboratory Charges	Charges obtained from HCFA-1453, Line 19N
28.	Radiology Charges	Charges obtained from HCFA-1453, Line 19M
29.	Supplies Charges	Charges obtained from HCFA-1453, Line 19O

	Information	Description
30.	Anesthesia Charges	Charges obtained from HCFA-1453, Line 19I
31.	Inhalation Therapy Charges	Charges obtained from HCFA-1453, Line 19S
32.	Type of Hospital	-General Short Term -General Long Term -Tuberculosis -Psychiatric -Chronic Disease -Specialty Short Term -Christian Science -Other
33.	Number of Facilities and Services	Actual number of facilities and services available to the beneficiary by this provider
34.	Medical School Affiliation	-No -Yes
35.	Adult Bed Capacity	Actual number of certified hospital beds in this provider
36.	Type of Control	-Government non-Federal -Church -Proprietary -Federal -Other non-profit
37.	Principal Diagnosis	ICD-9-CM code
	a. Source of Coding	Indicates where the diagnosis was coded -Provider -HCFA (Central Office)
38.	Additional Diagnosis Indicator	-Yes -No -Unknown

NOTE: Beginning 1984 this field will contain codes for up to four additional diagnoses.

Exhibit B

Information	Description
39. Date of Surgery	Date surgery was performed
40. Principal Surgical Procedure Code	ICD-9-CM Volume III
a. Source of Coding	Indicates where the surgery was coded -Provider -HCFA (Central Office)
41. Additional Surgery Indicator	-Yes -No -Unknown

NOTE: Beginning 1984 this field will contain codes for up to two additional surgical procedures.

42. Surgery Indication	-Yes -No
43. Blood Furnished (Pints)	Whole pints
44. DRG Number	Diagnosis Related Group

Exhibit C

MEDPAR Public Use File

	Information	Description
1.	DRG Number	Diagnosis Related Group
2.	MDC	Major Diagnostic Category
3.	Medicare Status Code	-Aged -Aged with End Stage Renal disease -Disabled -Disabled with End Stage Renal disease -End Stage Renal Disease Only
4.	Day of Admission	Sunday Monday Tuesday Wednesday Thursday Friday Saturday
5.	Discharge Status	-Discharged alive -Dead
5a.	Discharge Destination (Beginning 1984)	-Home -Another hospital -SNF -ICF -Another institution -Home health care -Left against medical advice
6.	SMSA/NON-SMSA Codes	Standard Metropolitan Statistical Area Code
7.	Length of Stay	Total length of the hospital stay. Date of admission through date of discharge.
8.	Covered Days	Number of covered days in the stay
9.	Total Charges	Total amount of all expenses in this stay
10.	Covered Charges	Amount of covered charges in this stay
11.	Intensive Care and Coronary Care Days	Total days obtained from HCFA-1453, Lines 19E and 19F
12.	Total Departmental (Ancillary) Charges	Total amount of all ancillary charges obtained from HCFA-1453, sum of lines 19H through 19T

	Information	Description
13.	Operating Room Charges	Charges obtained from HCFA-1453, Line 19H
14.	Pharmacy Charges	Charges obtained from HCFA-1453, Line 19L
15.	Laboratory Charges	Charges obtained from HCFA-1453, Line 19N
16.	Radiology Charges	Charges obtained from HCFA-1453, Line 19M
17.	Supply Charges	Charges obtained from HCFA-1453, Line 19 O
18.	Anesthesia Charges	Charges obtained from HCFA-1453, Line 19 I
19.	Inhalation Therapy Charges	Charges obtained from HCFA-1453, Line 19S
20.	Principal Diagnosis	ICD-9-CM Code
21.	Additional Diagnosis Indicator	-Yes -No -Unknown

NOTE: Beginning 1984 this field will contain codes for up to four additional diagnoses.

22.	Principal Surgical Procedure Code	ICD-9-CM Volume III
23,	Additional Surgery Indicator	-Yes -No -Unknown

NOTE: Beginning 1984 this field will contain codes for up to two additional surgical procedures.

24.	Surgery Indicator	-Yes -No
25.	Age	Age as of last birthday on date of admission
26.	Sex	-Male -Female -Unknown
27.	Blood Furnished (pints)	Whole pints

Exhibit D

Skilled Nursing Facility Stay Record

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Transaction Code	-Christian Science SNF -Regular SNF
3.	Date of Birth	Year and Julian date of beneficiary's birth
4.	Sex	-Male -Female -Unknown
5.	Race	-White -Black -Other -Unknown
6.	State - County Code	-SSA Geographic codes obtained from HI Master Record indicating State and County of beneficiary's residence
7.	Dual Entitlement to SSA-RRB Benefits	-No -Yes
8.	State Buy-In	-No -Yes
9.	Cross-Reference Account Number	Beneficiary's cross-reference claim number
10.	Medicare Provider Number	Identification number of the provider submitting the claim
11.	Admission Date	Year and Julian date the beneficiary entered the care of the provider
12.	Discharge Date	Year and Julian date the beneficiary left the care of the provider or died
13.	Age at Admission	Beneficiary age as of last birthday at date of admission

Exhibit D

Information	Description
14. Admitting Diagnosis	Codes indicating the diagnosis upon admission. ICD-9-CM, Volumes I and II
a. Source of Coding	Indicates where the diagnosis was coded -Provider -HCFA (Central Office)
15. Additional Diagnosis	-Had no additional diagnosis -Had additional diagnosis -Unknown
16. Utilization Review Date	Year and Julian date of review of the patient's need for continued SNF care
17. Benefits Exhausted Date	Year and Julian date coverage was exhausted
18. Discharge Status	-Discharged alive -Died -Benefits exhausted
19. Type of Bills Used	-Initial debit bills only
20. Date Stay Created	Year and month stay record was created
21. Number of Bills Used for this Stay	Total number of bills used to create stay
22. Forwarding Date	Year and Julian date the final bill was forwarded by the SNF to the intermediary
23. Approval Date	Year and Julian date the final bill was approved by the intermediary
24. Date Care Ended	Year and Julian date of determination by the intermediary that active care, as defined by the Medicare Program, has ended and payment was stopped

Exhibit D

Information	Description
25. Intermediary Number	Identification number of the intermediary processing the claim
26. Guarantee of Payment Date	Last date the provider is guaranteed payment of services for an uncertified beneficiary
27. Accommodations	-1 bed facility -2-4 bed facility -5 or more bed facility
a. Number of days	Number of days in Stay
b. Total charge	Total charges for accommodation
c. Covered charge	Total covered charges for accommodation
	(1) The above information is shown for each of the 3 types of accommodations
29. Total Accommodation Days	Total of all accommodation days
30. Covered Charges	Total amount of all covered charges
31. Non-Covered Charges	Total amount of the non-covered expenses for this stay
32. Total Charges	Total amount of all expenses in this stay
33. Services Used and Related Charges	
a. Service Code	Type of service used -Blood Administration -Pharmacy -Laboratory -Medical, Surgical and Central Supplies -Physical Therapy -Occupational Therapy -Speech Therapy -Inhalation Therapy -Other Each service field contains total charge field and a covered charge field of dollars only

Exhibit D

	Information	Description
	b. Service Charge	Total charge for this service
	c. Covered Charge	Covered charge for this service
		(1) The above information is shown for each of the possible 10 types of service
34.	Amount Not Reimbursed	Total amount of charges less amount reimbursed
35.	Coinsurance Days	Number of coinsurance days used in the stay
36.	Coinsurance Amount	Amount of the coinsurance incurred in this stay
37.	Reimbursement Amount	The reimbursement amounts shown are interim payments made to the hospital. Final reimbursement is made on a cost basis based on the cost report each hospital is required to prepare at the end of their fiscal year.
38.	Accommodations-Total Covered Charges	Total amount of covered charges from all accommodations
39.	Covered Days	Number of covered days in this stay
40.	Length of Stay	Total length of stay
41.	Medicare Status Code	-Aged -Aged with End Stage Renal disease -Disabled -Disabled with End Stage Renal disease -End Stay Renal Disease only
42.	Original Reason for Entitlement	-OASI -DIB -Renal -Renal and DIB
43.	Current Reason for Entitlement	-OASI -DIB -Renal

Exhibit D

Information	Description
44. End Stage Renal Disease	Source of notification of ESRD -No ESRD -MBR -HI -NIH -MBR/HI -MBR/NIH -HI/NIH -MBR/HI/NIH
45. Qualifying Stay Date-(From)	Year and Julian "from" date of the stay in a hospital that qualified the claimant for this SNF stay
46. Qualifying Stay Date-(To)	Year and Julian "to" date of qualifying hospital stay

Exhibit E

Skilled Nursing Facility Stay Record Skeleton Write-Off

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Date of Birth	Year and Julian date of beneficiary's birth
3.	Sex	-Male -Female -Unknown
4.	Race	-White -Black -Other -Unknown
5.	State-County Code	SSA Geographic codes obtained from HI Master Record indicating State and County of beneficiary's residence
6.	ZIP Code of Residence	Actual
7.	Medicare Provider Number	Identification number of the provider submitting the claim
8.	Admission Date	Year and Julian date the beneficiary entered the care of the provider
9.	Discharge Date	Year and Julian date the beneficiary left the care of the provider or died
10.	Benefits Exhausted Date	Year and Julian date coverage was exhausted
11.	Discharge Status	-Discharged alive -Died -Benefits exhausted
12.	Qualifying Stay Date-(From)	Year and Julian "from" date of stay in a hospital that qualified the claimant for this SNF stay
13.	Qualifying Stay Date-(To)	Year and Julian "to" date of qualifying hospital stay

Exhibit E

	Information	Description
14.	Admitting Diagnosis	Codes indicating the diagnosis upon admission. ICD-9-CM, Volumes I and II
	a. Source of coding	Indicates where the diagnosis was coded -Provider -HCFA (Central Office)
15.	Additional Diagnosis	-Had no additional diagnoses -Had additional diagnoses -Unknown
16.	Accommodations-Total Covered Charges	Total amount of all covered charges from all the accommodations
17.	Total Covered Charges	Total amount of all covered charges
18.	Coinsurance Days	Total number of coinsurance days used in the stay
19.	Coinsurance Amount	Total amount of the coinsurance incurred in this stay
20.	Reimbursement Amount	The total of reimbursable expenses. The reimbursement amounts shown are interim payments made to the hospital. Final reimbursement is made on a cost basis based on the cost report each hospital is required to prepare at the end of it's fiscal year.
21.	Covered Days	Number of covered days in this stay
22.	Total Days	Total length of stay
23.	Medicare Status Code	Coded to show the reason for beneficiary's entitlemenmt to Medicare benefits -Aged only - no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
24.	Age at Date of Admission	Age as of last birthday at date of admission

VII. Part B Payment Records

Introduction

Part B Supplementary Medical Insurance (SMI) benefits are payable for physician's services, home health service visits, outpatient hospital services and other medical services and supplies. Medical insurance benefits for home health services and outpatient hospital services, where the bills are processed by a Part A Intermediary, are covered in other chapters. This chapter relates to physician services and other medical services and supplies where the requests for payment are processed by Part B carriers. Payments are generally made on a charge basis and are generally subject to both an annual deductible amount and a coinsurance amount. Specific medical services not subject to any deductible or coinsurance amounts are detailed in the "Preparation of the Payment Record" portion of this chapter. Payments for services can be made directly to a physician (or other supplier of medical services) if they accept assignment or to the beneficiary if assignment is not accepted by the physician or supplier. Basically three forms are used to request payment. (See Exhibits C-E for copies of these forms).

1. The Forms HCFA-1490/1500/1490S are the basic Part B claim forms used by either the patient or physician (supplier) to claim reimbursement. (Form HCFA-1490 was used prior to Forms HCFA-1500 or HCFA 1490S).

2. The Form HCFA-1554 is used by hospitals to bill for hospital based physician services.

3. The Form HCFA-1556 is used by Group Practice Prepayment Plans dealing through a carrier, where reimbursement is based on reasonable charges.

HCFA, which has the basic responsibility for administering the SMI program, enters into agreements with public or private organizations which serve as carriers to help administer the medical insurance benefit claims process. These contractor organizations, using HCFA coverage and claims processing guidelines, determine which services are covered, the amounts payable, and make payment to providers and beneficiaries. They also communicate utilization and benefit information to HCFA.

Carriers prepare and send to HCFA a payment record for every bill for which reimbursement is made under the Supplementary Medical Insurance Program. The payment record has very important administrative and statistical uses. The primary purpose of the payment record is to enable HCFA to equate the amount of reimbursement shown on the payment record to the amount reported and disbursed on the Monthly Intermediary Financial Reports (Form HCFA-1522) submitted by the carriers. Other areas in which payment record data are used extensively are:

a. To provide current information on supplementary medical insurance benefit payments and to make possible the preparation of a variety of operating statistics.

b. To provide information to assist in the conduct of administrative and fiscal audits of carrier operations.

c. To draw samples for special ad hoc studies focusing on specific groups of physicians and suppliers, costly procedures, specific types of services, and specific geographic areas.

d. To provide current information to assist in preparing a variety of program statistics tabulations.

e. To provide a 100% base from which either samples or 100% file may be used to provide data needed for actuarial calculations.

Because of their importance, all carriers prepare payment records uniformly in accordance with the instructions contained in the Medicare Carrier's Manual and transmit them promptly to HCFA.

The Bureau of Support Services (BSS) handles the automated processing of payment records and has the responsibility to determine the appropriateness of payments made by carriers based on a computer analysis of the data contained in the payment records and the related Health Insurance Master Record data. Entitlement to benefits during the period in which expenses were incurred, deductible satisfied, proper computation of the reimbursable amount, etc., are monitored in the data edit/validation processes. Inconsistencies detected are returned to the carriers for investigation, correction and resubmission. A "suspense" file of all rejected records is maintained by BSS to ensure their return. As these records are corrected and returned, they are deleted from the suspense file and processed in the utilization routines.

Preparation of the Payment Record

A payment record is prepared by a carrier after the amount of reimbursement on an individual bill has been determined and payment has beem made to the physician or the beneficiary (or on his or her behalf). A "bill" is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or single supplier. A payment record is submitted for every bill for which reimbursement is made. No payment record is prepared for any bill for which no reimbursement is made. Situations will arise--e.g., overpayments or incomplete information--where carriers determine that the amount reimbursed for a specific bill is incorrect and needs to be adjusted. In those instances, a corrected payment record is submitted.

The number of bills on a request for payment is determined by the number of different beneficiary-physician (or supplier) relationships represented. For example, a request for payment accompanied by itemized statements from only one physician or supplier constitutes only one bill, regardless of the number of occasions of service. A request for payment accompanied by itemized statements from two physicians or suppliers constitutes two bills, etc.

The definition of a payment record is generally the same as that of a bill. A request for payment from a beneficiary accompanied by one or more itemized statements from the same physician requires preparation of only one payment record. On the other hand, if a beneficiary had accumulated and submitted itemized statements from two physicians for medical treatment and from an orthotist for fitting and purchase of an artifical leg and reimbursement was made for the services of all three, the carrier prepares three payment records--one for each physician's services and one for the orthotist's services.

Separate payment records are prepared when a bill is submitted for services rendered in different calendar years in each of which the deductible had been met and reimbursement made.

Separate payment records are also prepared for bills submitted covering specific services requiring special payment procedures designated by Amendments to the Medicare Law. These services include:

1. Hospital-based Radiologists and Pathologists

   Effective October 1, 1982, inpatient radiology and pathology services became reimbursable on the same basis as for other physician services, i.e., 80% of the reasonable charge after the Part B deductible has been met.

   Prior to October 1982, Medicare reimbursed these services at 100% of reasonable charges with no deductible or coinsurance applied.

2. Diagnostic Laboratory Fees Reimbursed at a Negotiated Rate

Beginning October 30, 1972, services performed in a laboratory that are billed on an assignment basis may be reimbursed at 100 percent of a negotiated rate with no deductible or coinsurance applied. This applies only to those laboratories which have negotiated a rate agreement with the carrier.

3. Independent Physical Therapists

Beginning July 1, 1973, services performed by an independent physical therapist in the therapist's office or in the patient's home became covered up to a maximum of $100 a year. A separate payment record is prepared for each bill for services performed by an independent therapist until the maximum expense has been incurred.

4. Physician Services Provided to Living Kidney Donors

Beginning October 1, 1978, physician services provided to living kidney donors are reimbursed at 100 percent. These services include monies for both the kidney donation surgery and the post-operative recovery period. These services are billed to the program under the name and HI Claim Number of the recipient.

5. Used Durable Medical Equipment (DME)

Beginning November 1, 1977, the purchase of used DME became reimbursable at 100 percent of the reasonable charge less any deductible yet to be met. The used DME charge, however, cannot exceed 75 percent of the cost of new DME.

6. Pneumococcal Vaccine

Effective July 1, 1981, carriers were authorized to reimburse beneficiaries/physicians 100% of the reasonable charge of the cost and administration of pneumococcal vaccine. Both deductible and coinsurance will be waived for this service.

NOTE: Although separate payment records are prepared for the above types of service, the beneficiary, physician, calendar year relationship must still exist in all payment records produced.

Whenever payment is made for purchase of durable medical equipment, a payment record is also prepared. If the payments are spread out over a period of months a payment record is also prepared for each payment even though monthly bills are not submitted.

The 1967 Amendments established, effective January 1, 1968, a separate Part B blood deductible. This deductible is equal to the charge for the first three (3) pints of blood furnished an individual in a calendar year. When a Request for Payment is received for blood charges, no payment record is prepared if those charges represent blood used to satisfy the Part B blood deductible. Charges for blood after the blood deductible has been satisfied and for which payment is made requires the preparation of a payment record.

Deviations are not made from the procedures discussed above for preparing payment records on a "bill" basis. In addition, the format of the payment records and codes to be used for individual fields must conform exactly to those detailed in Exhibit A.

Contents of the Payment Record

For purposes of this manual, a description of payment records used in statistical programs is available in Exhibit A. Generally, carriers code all fields, using the same coding criteria. However, some hospitals claim reimbursement for hospital-based physicians' services on Form HCFA-1554 on a per diem or other unit of time bases. This method is used by a few hospitals that charge a fixed, all-inclusive rate computed on a per diem, per visit, or other time basis, which is applicable uniformly to each patient regardless of services received and without distinction between hospital services and physicians'services. Where hospitals claim reimbursement for hospital-based physicians on a per diem or unit time basis and submit HCFA-1554's without specifying the department providing treatment, a single abbreviated payment record is prepared. Where hospitals claim reimbursement for hospital-based physicians' services on a per diem or per visit time basis but provide details of services on a departmental basis or where hospitals do not use the per diem or per unit time method, completely coded payment records are prepared and submitted.

Approximately 150 million payment records are received annually.

Exhibit A

Payment Record Contents

Information	Description
1. HI Claim Number	Beneficiary's Health Insurance claim number
2. Zip Code of residence	Actual
3. Entry Code	A code for type of payment record being submitted: -Original debit -Supplemental debit -Full Credit -Partial credit -Replacement debit -Partial debit
4. Entry Recode	-Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records -Acknowledge an A reject previously submitted
5. Beneficiary's Name a. Surname b. First Initial	
6. Medicare Status Code	Beneficiary's Status -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
7. Physical Therapy Indicator	-No physical therapy involvement -Physical therapy involvement
8. Receipt Date-HCFA	Year and Julian date of receipt into the EDP system
9. Original Reason for Entitlement	-OASI -DIB -Renal

Exhibit A

Information	Description
10. End Stage Renal Disease Indication	-MBR notice of ESRD -HI notice of ESRD -NIH notice of ESRD -MBR/HI notice of ESRD -MBR/NIH notice of ESRD -HI/NIH notice of ESRD -MBR/HI/NIH notice of ESRD
11. Carrier Bill Dates	
a. Date Bill Received	Year and Julian date the bill is received by carrier
b. Date Bill Paid	Year and Julian date carrier indicates on the benefit check. Where the carrier makes payment to physicians on a periodic basis through pre-arrangement, the date paid reflects the date the carrier would have ordinarily prepared the check if the physician were not reimbursed on a periodic basis.
12. Carrier Number	Unique identification number assigned by HCFA
13. Expense Dates	Period for which expense incurred
First Expense Date	-Indicates year and first Julian day of the month in which expense period began
Last Expense Date	-Indicates year and first Julian day of the month in which expense period ended

Exhibit A

Information	Description
14. Outpatient Psychiatric Charges	The outpatient Psychiatric expense represents 62 1/2% or $312.50 (whichever is less) of the reasonable psychiatric charges for the items on the Request for Payment Form for which payments have been made
15. Reimbursement Amount	The amount of payment made to or on behalf of the beneficiary
16. Carrier Batch Number Batch Year	-Unit position of the year in which batch was created
Batch Month	-Month in which the batch was created
Batch Sequence Number	-01-69-Payment batches -70-99-Correction batches
17. Current Reason for Entitlement	-OASI -DIB -Renal
18. Reasonable Medical Charges (Non-Psychiatric)	The reasonable charges for the non-psychiatric items on the Request for Payment form for which payment has been made NOTE: Payment records submitted for paymenmt of services of an independent physical therapist contain a "p" in the high order position of this field
19. Deductible Applied	Amount of incurred expenses in this record which were applied to the deductible. All nines in field indicate 100% reimbursement.

Exhibit A

Information	Description
20. Carrier Control Number	Unique control number assigned each payment record by carrier
21. Control Number Check Character	Assigned by HCFA to ensure unique control for identification of each payment record
22. Physician or Supplier Identification code	The number used to identify each individual physician, group, clinic or medical supplier, ambulance service, clinical laboratory, medical supply house, etc. Social Security Account Numbers are to be used for solo-practice physicians and sole-proprietorship suppliers where the request for payment is reimbursed on a fee for service basis Employer Identification Number The EI number is to be used when identifying groups, partnerships or clinics. EI numbers are also used for independent laboratories, group practice prepayment plans and other entities who bill in a group or company's name including physician's billing through a provider as hospital-based physicians.

Information	Description
	Other Identification Numbers Unique identification numbers assigned by the carriers are to be used if the social security or employer identification number is not available. Such usage should be very limited and occur only until valid Social Security or EI numbers can be obtained. NOTE: Vendors providing services outside the U.S. are assigned a unique number also. (The provider number assigned by HCFA or, if none available, a carrier assigned number).
23. Sex	-Male -Female
24. Number of Separate Charges	A count of the number of separate covered charges which the carrier has taken into consideration when making the reasonable charge determination. When a series of similar services are represented by an inclusive single charge, each occasion of service is counted as a separate charge. Ninety-nine is used for 99 or more separate charges.
25. Place of Service	Place of service is based on the item with largest single charge on the bill -Office -Home -Inpatient hospital -SNF/Nursing Home -Outpatient hospital -Independent laboratory -Independent Kidney Disease Treatment Center -Ambulatory Surgical Center -Other

Information	Description
26. Type of Service	Type of service is based on the items with the largest single charge on the bill -Medical care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic laboratory -Radiation therapy -Anesthesia -Assistance at surgery -Other medical service, including durable medical equipment -Charges for whole blood or packed red blood cells -Purchase of used DME (Effective 11/77) -Surgical second opinion (Effective 03/78) -Surgical third opinion (Effective 03/78) -Alternate payment method for maintenance dialysis -Live kidney donor -ASC Facility Usage -Renal supplies in the home -Pneumococcal vaccine The following are definitions of type of service used in assigning the codes listed above: Medical Care-Includes all physician services, including podiatrists and surgical chiropodists not elsewhere classified, and covers office visits, home visits, nursing home visits, and nonsurgical hospital visits. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are also included. Consultation is excluded.

Exhibit A

Information	Description
Type of Service (cont.)	Surgery-Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and covers services pertaining to incision, excision, repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation, and endoscopy
	Consultation-Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the evaluation and/or treatment of a patient
	Diagnostic X-Ray-X-Ray and related services undertaken for diagnostic purposes. Includes portable X-Ray services after 12/31/67
	Diagnostic Laboratory Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Also includes certain mechanical or machine tests such as EKG,EEG, BMT, etc.
	Ultrasound diagnostic procedures performed after 12/31/74 are also shown under this code
	Radiation Therapy Therapeutic services, such as X-Ray, radon, radium, and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, angiomas, vascular nevi, lymphomas, leukemia and thyroid disease

Exhibit A

Information	Description
Type of Service (cont.)	Anesthesia-Services for anesthesia including the appropriate pre- and post-operative visits, administration of anesthetic, and transfusion of fluids and/or blood incident to the anesthesia or surgery
	Assistance at Surgery Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such service prescribed by the carrier
	Other medical services Services falling in the following special categories: -Rental of durable medical equipment -Purchase of durable medical equipment after 12/31/67 -Ambulance service -Internal and external prosthetic devices and appliances -Supplies
	Charges for Whole Blood or Packed Red Blood Cells Includes bills where the charges are for whole blood or packed red blood cells and where reimbursement is made
	Purchase of Used Durable Medical Equipment Effective November 1977, specific carriers were authorized to reimburse beneficiaries/suppliers 100 percent of the reasonable charges for purchase of used DME if such charge does not exceed 75 percent of the cost of new DME

Exhibit A

Information	Description
Type of Service (cont.)	(Deductible must still be met). Initially only six carriers were involved. Additional carriers may be added subsequently. Surgical Second Opinion Effective March 1978 carriers are authorized to pay claims for patient-initiated second physician opinions pertaining to the medical need for surgery. Beneficiaries are responsible for applicable deductible and coinsurance amounts. Surgical Third Opinion Effective March 1978 carriers are also authorized to pay claims for patient-initiated third physician opinions pertaining to the medical need for surgery. As in type of service Y, beneficiaries are responsible for applicable deductibles and coinsurance amounts. Third opinion requests may occur if the initial and second physician opinions differ regarding the medical need for such surgery. Alternate Payment Method for Maintenance Dialysis Effective July 1975 physicians may elect to be paid on a monthly basis for all services rendered to maintenance dialysis patients

Information	Description
Type of Service (cont.)	Physicians Services Provided to Living Kidney Donors Effective October 1978, carriers were authorized to pay claims for physician services rendered to obtain kidney from a living donor. Services include monies for both the kidney donation surgery and post operative recovery period. These claims are paid under the name and HI claim number of the recipient. ASC Facility Usage- Effective September 1982 carriers were authorized to reimburse Ambulatory Surgical Centers for 100% of their cost of facility usage for Medicare beneficiaries Renal Supplies in the home- Cost of supplies used in the beneficiary's home in the treatment of end stage renal disease Pneumococcal Vaccine-Effective July 1, 1981, carriers were authorized to reimburse beneficiaries/physicians 100 percent of the reasonable charge of the cost and administration of pneumococcal vaccine
27. Type of Physician or Supplier ID Number	-Physicians or suppliers billing as solo-practitioners for whom SS numbers are shown in the physician ID code field -Physicians or suppliers billing as solo-practitioners for whom SS numbers are not available and the carrier's own physician ID code is shown -Suppliers (other than solo proprietorship) for whom employer identification numbers are used in coding the ID field

Information	Description
Type of Physician or Supplier ID Number (cont.)	-Suppliers (other than sole proprietorship) for whom employer ID numbers are not known and the carrier's own code has been shown
	-Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are used in coding the ID field. Hospitals include HHA & SNF providers.
	-Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are not available and provider numbers assigned by HCFA are shown. Hospitals include HHA & SNF providers.
	-Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field
	-Group practice prepayment plans for whom EI numbers are used in coding the ID field
	-Clinics, groups, associations, partnerships, or GPPP's for whom EI numbers are not available and therefore the carrier's own physician code has been assigned

Information	Description
28. Payment Code	A code indicating whether the payment being recorded was made to the beneficiary, to the physician or supplier, to both (partial payment to both the beneficiary and the physician or supplier on the same bill) or to a provider where the provider bills for the physician: -For payment to physician or supplier -For payment to beneficiary -For partial payment to both -For payment to hospital (hospital-based physicians) -For partial payment to both hospital and beneficiary -For payment to group practice prepayment plan -For payment to other entities, e.g., employer, union -For payment to all Federally funded entities NOTE: a. If beneficiary is deceased and payment would have been made to him or her if alive, payment to beneficiary is indicated

Information	Description
Payment Code (cont.)	b. Payment codes indicating payments to hospitals also include nursing facilities, or home health agencies where payment for the physicians' services are made directly to the facility
29. Physician or Supplier Specialty Code	A two-digit code for each physician or supplier indicating the physician's major speciality or type of supplier. See Exhibit B. The clinic specialty code (70) should be used only where all of the following conditions are met: (1) The association consists of physicians with mixed (more than one) specialties (2) Charges are uniform for a medical procedure regardless of the individual physician performing the services (3) The request for payment is submitted in the name of the association and not the physician who performed the service An association of two or more physicians may be considered a group (other than clinic) if both (2) and (3) above are met and the physicians involved are all one specialty. The group should be assigned the code applicable to that specialty.

Exhibit A

Information	Description
30. Region Code	Reflects the region of the carrier recording the payment: -Boston -New York -Philadelphia -Atlanta -Chicago -Dallas -Kansas City -Denver -San Francisco -Seattle -Railroad Board -Social Security
31. Exception Code	Indicates reason for payment record reject -Record accepted -Name/Number exception -Beneficiary never entitled to Part B -Payment record does not crossfoot -Invalid month of expense -No entitlement in the month of expense -Last month of expense is later than beneficiary month of death (one month tolerance) -Deductible not satisfied -Deductible in payment record exceeds $50 or $60 -Invalid entry code -Blood charges with no previous query containing blood -Radiology/Pathology or Diagnostic Lab testing -Psychiatric monies exceed the maximum -Physical therapy reject -Physical therapy monies exceed the maximum -HMO lockin

Exhibit A

Information	Description
32. State Code of Residence	
33. County Code of Residence	
34. Date of Birth	Year and Julian date of beneficiary's birth
35. Sex	-Male -Female -Unknown
36. Race	-White -Black -Other -Unknown

Exhibit B

Physician and Supplier Specialty Codes

For each request for payment involving physicians' services, carriers code the specialty of each physician rendering services. The 2 digit codes used are:

Code	Physician Specialization
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB - Gynecology
17	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic Surgery
21	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation

Exhibit B

Code	Physician Specialization
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopaths only)
32	Radiation Therapy (Osteopaths only)
33	Thoracic Surgery
34	Urology
35	Chiropractor, licensed (effective July 1973)
36	Nuclear medicine
37	Pediatrics
38	Geriatrics
39	Nephrology
40	Hand Surgery
48	Podiatry - Surgical Chiropody
49	Miscellaneous
70	Clinic or other group practice, except GPPP (see note below)
99	Unknown

Individual physicians are considered specialists if they consider themselves specialists and so classify themselves regardless of whether or not they are certified by specialty boards or eligible for certification. For physicians with more than one specialty, the carrier enters the major specialty of the physician on all his or her payment records and does not vary the specialty code with the different types of service reported for that physician.

NOTE: Use of code "70" above. Clinic code "70" is used:

(a) only where charges are uniform for a medical procedure regardless of the individual physician in the group or clinic performing the service; and

(b) only for those groups composed of physicians with mixed (two or more) specialties; and

(c) only where the request for payment does not identify the performing physician but is submitted in the name of the group.

Groups whose physician members are all one specialty should be assigned the code applicable to that specialty. Specialty code "70" should not be used for such groups.

NOTE: Specialty code use for services in an independent laboratory:

For services performed in an independent laboratory, if the request for payment was submitted by the physician ordering the tests or x-rays, this physician's speciality code will be shown. If the request for payment is submitted by the independent laboratory, type of supplier code "69" shown below will be used.

Coding Type of Supplier--Requests for payment involving services by suppliers other than physicians are coded with a type of supplier code as shown below.

Code	Type of Supplier
51	Medical supply company with C.O. (Certified orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification
52	Medical supply company with C.P. (Certified prosthetist-certified by American Board for Certification in Prosthetics and Orthotics) certification

Exhibit B

Code	Type of Supplier
53	Medical supply company with C.P.O. (Certified prosthetist-orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification
54	Medical supply company not included in 51, 52 or 53
55	Individual CO
56	Individual CP
57	Individual CPO
58	Individuals not included in 55, 56 or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public Health or Welfare Agencies (Federal, State and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities,Inc., etc.)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologists (Billing Independently)
65	Physical Therapist (Independent Practice) (July 1973)
69	Independent Laboratory (Billing Independently)
87	All other, e.g., Drug and Department Stores
88	Unknown

Coding Type of Service for Group Practice Prepayment Plans

The following codes are used to code type of service only for bills submitted by group practice prepayment plans on Form HCFA-1556. These codes are used only for services that do not involve a "visit" to a physician. A "visit" to a physician is defined as a formal face-to-face contact between the physician and the patient for purposes of diagnosis or treatment. For bills involving a "visit" to a physician, the specialty of the physician providing services are coded using the physician specialty codes shown on pages 1 and 2 of this exhibit.

Code	Type of Service
71	Diagnostic X-Ray
72	Diagnostic Laboratory
73	Physiotherapy
74	Occupational Therapy
75	Other Medical Care

Exhibit C

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back — Type or Print Information)

Form Approved OMB No. 068-R-0012

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT, TO FILL IN ITEMS 1 THROUGH 6 ONLY

Copy from YOUR OWN HEALTH INSURANCE CARD *(See example on back)*

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number *(Include all letters)*

☐ Male ☐ Female

3 Patient's complete mailing address (including Apt. no.) City, State, ZIP Code

Telephone Number

4 Describe the illness or injury for which you received treatment *(Always fill in this item if your doctor does not complete Part II below)*

Was your illness or injury connected with your employment?

☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below.

Name and address of organization or agency

Policy or Identification Number

Note: If you **Do Not** want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient *(See instructions on reverse where patient is unable to sign)*

Date signed

SIGN HERE

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (if lab service, indicate if automated)	Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges (if related to unusual circumstances explain in 7C)	Leave Blank
					$	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*

Telephone No.

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

☐ I accept assignment *(See reverse)* ☐ I do not accept assignment

13 Name and address of person or facility where services were furnished *(Complete if outside your own office or patient's residence)*

14 Signature of physician or supplier (I certify that the statements under Physicians' Notes on the reverse apply to this bill and are made a part hereof.)

Date Signed

O—Doctor's Office H—Patient's Home *(If portable X-ray services, identify the supplier)* SNF—Skilled Nursing Facility OL—Other Locations

IL—Independent Laboratory IH—Inpatient Hospital OH—Outpatient Hospital NH—Nursing Home

FORM HCFA-1490 (5-78) FORMERLY SSA-1490) Department of Health, Education and Welfare - Health Care Financing Administration

Exhibit C

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

Form Approved
OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3 INSURED'S NAME *(First name, middle initial, last name)*
4 PATIENT'S ADDRESS *(Street, city, state, ZIP code)* TELEPHONE NUMBER	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6 INSURED'S I.D. MEDICARE AND/OR MEDICAID NO *(Include any letters)* 8. INSURED'S GROUP NO. *(Or Group Name)*
9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. AN ACCIDENT AUTO ☐ OTHER ☐	11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *(Read back before signing)* I Authorize the Release of any Medical Information Necessary to Process the Claim and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below *SIGNED* *DATE*		13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW* *SIGNED (Insured or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐	16a IF AN EMERGENCY CHECK HERE ☐	
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM ☐ THROUGH ☐	DATES OF PARTIAL DISABILITY FROM ☐ THROUGH ☐		
19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE *(e.g., public health agency)*		20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED ☐ DISCHARGED ☐		
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES		

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC OR DX CODE

A
1
2
3
4

B
EPSDT YES ☐ NO ☐
FAMILY PLANNING ☐ NO ☐
PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM TO	B * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * TOS	H LEAVE BLANK

25 SIGNATURE OF PHYSICIAN OR SUPPLIER *(I certify that the statements on the reverse apply to this bill and are made a part hereof)* SIGNED DATE	26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐ 30 YOUR SOCIAL SECURITY NO	27 TOTAL CHARGE	28 AMOUNT PAID / 29 BALANCE DUE
32 YOUR PATIENT'S ACCOUNT NO	33 YOUR EMPLOYER I.D. NO	31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO I.D. NO	

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5-80
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

Form HCFA-1500 (C2) (10-80

Exhibit C

Form Approved
OMB No. 66-R0012

PATIENT'S REQUEST FOR MEDICARE PAYMENT

IMPORTANT— SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary From Health Insurance Card
(First) (Middle) (Last)

SEND COMPLETED FORM TO:

2 Claim Number From Health Insurance Card

☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address → ☐

(Street or P.O. Box—Include Apartment number)

(City) (State) (Zip)

3b Telephone Number (Include Area Code)

4 Describe The Illness or Injury for Which Patient Received Treatment

4b Was illness or injury connected with employment?
☐ Yes
☐ No

If any medical expenses will be or could be paid by your private insurance organization, State Agency, (Medicaid), or the VA complete block 5 below.

5 Name and Address of other insurance, State Agency (Medicaid), or VA office

Policy or Medical Assistance Number

NOTE: If you DO NOT want payment information on this claim released put an (x) here → ☐

I authorize Any Holder of Medical or Other Information About Me to Release to the Social Security Administration and Health Care Financing Administration or Its Intermediaries or Carriers any Information Needed for This or a Related Medicare Claim. I Permit a copy of this Authorization to be Used in Place of the Original, and Request Payment of Medical Insurance Benefits to Me.

6 Signature of Patient (If patient is unable to sign, see Block 6 on other side.)

6b Date Signed

IMPORTANT!

ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM.

Exhibit D

PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS

MEDICAL INSURANCE BENEFITS — SOCIAL SECURITY ACT

(Use this form only where the provider has billing arrangement to collect physicion charges for individual potient care pursuant to agreement with the physician.)

Form Approved.
OMB No. 72-R747

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX ☐ M ☐ F	3. HEALTH INSURANCE CLAIM NUMBER
4. PATIENT'S ADDRESS *(Street number, City, State, Zip Code)*			5. DATE OF BIRTH	6. MEDICAL RECORD NO.
7. NAME AND ADDRESS OF PROVIDER				7a. PROVIDER NO.

8. If the patient wishes to authorize release of information abaut this claim upon its request to anather organizotion which provides health insurance for him, or to his State medical assistance agency, please give the following information.

INSURING ORGANIZATION OR STATE AGENCY NAME AND ADDRESS	POLICY OR MEDICAL ASSISTANCE NUMBER

9. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this autharization to be used in place of the original, ond request payment of medical insurance benefits to the party who accepts assignment below.

☐ SIGNATURE CONTAINED IN PROVIDER'S RECORD	SIGNATURE *(Potient or authorized representative) (Signature by mark must be witnessed)*	DATE

10A. DATE OF EACH SERVICE	B. PLACE OF SERVICE (1)	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	D. PHYSICIAN IDENTIFICATION INFORMATION	E. CHARGE FOR PHYSICIANS SERVICES	LEAVE BLANK
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE / PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE / PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE / PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE / PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE / PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE / PERCENT OF CHARGE		

(1) CODES IH-INPATIENT HOSPITAL, OH-OUTPATIENT HOSPITAL, ECF-EXTENDED CARE FACILITY, H-HOME HEALTH AGENCY

11 DIAGNOSIS AND CONCURRENT CONDITIONS	TOTALS	$	
	Amount paid by Beneficiary		
12 EMPLOYMENT RELATED *(If Yes, give name and address of employer)* ☐ YES ☐ NO	Any unpaid Balance		

13. PROVIDER CERTIFICATION: The physicians who performed the services described above have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE	DATE

Exhibit E

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

PREPAYMENT PLAN FOR GROUP MEDICAL PRACTICES DEALING THROUGH A CARRIER
MEDICAL INSURANCE BENEFITS – SOCIAL SECURITY ACT

Form Approved.
OMB No. 72-R0773

NOTICE Anyone who misrepresents or falsifies essential information requested by this form may, upon conviction be subject to fine and imprisonment under Federal law

NAME AND ADDRESS OF GROUP PRACTICE PREPAYMENT PLAN	Copy from HEALTH INSURANCE CARD ➧	NAME OF PATIENT ADDRESS *(Street address, City, State, ZIP Code)*
	GPPP NO.	CLAIM NUMBER ☐ MALE ☐ FEMALE

REPORT OF SERVICES – SEE INSTRUCTIONS ON REVERSE SIDE

1. a DATE OF EACH VISIT OR SERVICE	b PLACE OF VISIT OR SERVICE[2]	c PHYSICIAN SPECIALTY OR SUPPLIER CODE[1]	d FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	e DIAGNOSIS	f CHARGES	LEAVE BLANK

3. ARE ANY SERVICES, ILLNESSES OR INJURIES DESCRIBED IN ITEM 1 EMPLOYMENT RELATED?
☐ Yes ☐ No *(If "yes," indicate which one(s) and give name and address of employer below.)*

2. TOTALS		
4. Deductible and coinsurance paid		
5. Any unpaid balance		

The above named organization has in file and currently in effect an assignment by this patient of amounts payable under Part B of Title XVIII of the Social Security Act for medical services furnished him by it or under arrangements made by it. The organization hereby accepts such assignment with the understanding that under its terms the reasonable charge for any service as determined by the carrier shall be the full charge for the service.

6. SIGNATURE OF AUTHORIZED REPRESENTATIVE OF GROUP PRACTICE PREPAYMENT PLAN	7. DATE

[1] *See reverse for listing of codes to be used in this block.*
[2] O–Doctor's Office C–Clinic IH–Inpatient Hospital ECF–Extended Care Facility IL–Independent Laboratory *(give name & address in 1D)*
H–Patient's Home OH–Outpatient Hospital NH–Nursing Home OL–Other Locations *(Specify in 1D)*

FORM SSA-1556 (10-70)
HCFA

VIII. Five Percent Sample Bill Summary Record

Introduction

The Supplementary Medical Insurance Program provides coverage for a variety of medical services for those individuals who are enrolled in the program and have paid the required premium. Reimbursement for covered services is made on the basis of reasonable charge determinations and is generally subject to both an annual deductible and a coinsurance amount. Payments are made directly to the physician/supplier or to the beneficiary after review by the contractor (carrier) designated to process these claims.

Monies expended by carriers for payment of claims are reported to HCFA by use of payment records (see Chapter VII). These payment records serve a very important administrative and statistical purpose. Each payment record submitted contains coded type and place of service based on the largest single charge present on the bill. However, the need of a more detailed data file for use in obtaining health care services resulted in the creation of the Five Percent Sample Bill Summary Record. This file provides utilization data not available elsewhere. For example, the Sample Bill Summary Record (BSR) file shows total submitted charges as well as allowed charges not only for the total bill but also for type and place of service combinations. The BSR file also includes records for bills for which the beneficiary's deductible has not yet been met.

Preparation of Sample Bill Summary Records

The information contained on the summary record is based on data obtained from bills submitted to the carrier on Forms HCFA-1490, HCFA-1490W, HCFA-1490U, HCFA-1491, HCFA-1500 and HCFA-1556, and any appropriate attachments. A bill is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or supplier. The summary record is then prepared for each of these bills where the beneficiary's health insurance claim number falls into the five percent sample. (See Exhibits C and E, Chapter VII, for copies of forms.)

> Note: Information contained on Form HCFA-1554 (Provider Billing for Patient Services by Physician) is not collected because methods of reporting data vary by provider, and are not comparable to other information collected in this system.

A summary record is prepared based on the line items for each bill used by the carrier as input data in preparing the reasonable charge determinations or in preparing the Explanation of Medicare Benefits (EOMB). One summary record is prepared for each sample bill; however, if services on a bill cover overlapping years, separate summary records are prepared for each year. Also, summary records are prepared for each bill regardless of the deductible status of the beneficiary. Summary records are not prepared in the following instances:

1. For bills that are totally disallowed

2. For bills that are duplicates of a previously submitted summary record

3. For any adjustments of a previously submitted summary record

4. For covered Medicare services which are disallowed because of overutilization

Note: Bill summary records do not reflect those portions of a bill that represent non-covered services.

When a bill involves the rental of durable medical equipment (DME), each bill indicating rental fees is included in the summary record. A bill submitted for the purchase of DME is included only once in the summary record, when the claim is first received, and shows the total charge for the DME. This applies whether the beneficiary is reimbursed in a lump sum or by the diary method.

Summary records are coded as follows:

1. Each summary record must contain valid type and place of service combination codes

2. When the same type and place of service combination is included two or more times on a single bill, the services are combined into a single group and the number of services and charges are aggregated

3. Each group of valid type and place of service combinations is coded separately beginning with the first series of fields and repeated as necessary, until up to 18 separate type and place of service combinations are used

4. Where the number of separate combinations is greater than 17, the remaining combinations are aggregated and coded with the type of service based on the largest allowed charge of all the remaining services. The place of service in this 18th combination is left blank. Note: This is a very rare occurence.

Where services are grouped as described above, the number of services and related money amounts are aggregated.

After the summary records are prepared carriers process all records through an edit program provided by HCFA. This program checks consistency of the data contained in each record and produces a report reflecting the number of errors. Carriers are expected to correct all errors before accumulating and submitting the records monthly to HCFA.

Upon receipt at HCFA, all summary records are processed in an edit program similar to the one provided the carriers. Any tape containing excessive errors or that is unreadable is sent back to the carrier. The carrier must then correct the records and resubmit the summary record tape.

Contents of the Bill Summary Record

The summary record is a fixed length record submitted on magnetic tape which provides information identifying the beneficiary, the physician/ supplier and detailed data for up to a maximum of 18 type and place of service combinations that may be reported on individual bills. All positions of the record are either completed with the appropriate data or left blank. Exhibit A provides detailed description of each field of the record. Approximately 6,500,000 summary records are submitted each year.

Exhibit A

Five Percent Sample
Bill Summary Record

	Information	Description
1.	HI Claim Number	The beneficiary's Health Insurance claim number
2.	Sex	-Male -Female -Unknown
3.	First Expense Month	The month of the earliest covered incurred expense. Digits 01-12 for January-December.
4.	Last Expense Month	The month of the most recent incurred covered expense. First expense month repeated if all covered expenses were incurred in the same month.
5.	Expense Year	Unit position of the year in which expenses were incurred. NOTE: If services overlap years, separate records are prepared for each year.
6.	Total Submitted Charges for Covered Medicare Services	The total charges for all covered services NOTE: Field will reflect total charges submitted even if later reduced because of a lower reasonable charge determination
7.	Total Reasonable Charges	The total reasonable charges for all covered services. For outpatient psychiatric expenses, 62 1/2% or $312.50 (whichever is less) of the reasonable psychiatric charges is shown for the items on the request for payment form for which payments have been made.

Exhibit A

	Information	Description
8.	Total Reimbursement	The total amount of payment made to or on behalf of the beneficiary. Blank if all allowed charges are credited to the deductible
9.	Deductible Applied	Amount of the incurred expenses in this Summary Record which were applied to the deductible
10.	Physician/Supplier Specialty Code	A two-digit code for each physician or supplier indicating the physician's major specialty or the type of supplier. See Exhibit B, Chapter VII, for detailed codes. The clinic specialty code (70) is used only where all of the following conditions are met: (1) The association consists of physicians with mixed (more than one) specialties (2) Charges are uniform for a medical procedure regardless of the individual physician performing the service (3) The request for payment is submitted in the name of the association and not the physician who performed the service

Exhibit A

Information	Description
	An association of two or more physicians may be considered a group (other than clinic) if both (2) and (3) above are met and the physicians involved are all one specialty. The group should be assigned the code applicable to that specialty.
11. Physician/Supplier Identification Number	Social Security Account Numbers--are used for solo-practice physicians and sole-proprietorship suppliers where the request for payment is reimbursed on a fee for service basis Employer Identification Number--the EI number is used when identifying groups, partnerships, or clinics. EI numbers are also used for independent laboratories, group practice prepayment plans and other entities who bill in a group or company's name including physicians billing through a provider as hospital-based physicians. Other Identification Numbers--Unique identification numbers assigned by the carriers are used only if the social security or employer identification number is not available. Such usage should be very limited and occur only until valid SS or EI numbers can be obtained. NOTE: Vendors providing services outside the U.S. are assigned a unique number also. (The provider number assigned by HCFA or, if none available, a carrier assigned number).

Exhibit A

Information		Description
12.	Type of Physician/Supplier ID Number Shown in Field 38-46	Code: -Physicians or sole-proprietorship suppliers for whom SS numbers are shown in the physician ID code field -Physicians or sole-proprietorship suppliers for whom SS numbers are not available and the carrier's own physician ID code is shown -Suppliers (other than sole-proprietorships) for whom numbers are used in coding the ID field -Suppliers (other than sole proprietorships) for whom numbers are not known and the carrier's own ID code has been shown -Hospitals and independent laboratories for whom EI numbers are used in coding the ID field -Hospitals and independent laboratories for whom EI numbers are not available and provider numbers assigned by carrier or HCFA are shown -Clinics, groups, associations or partnerships for whom EI numbers are used in coding the ID field

Exhibit A

Information	Description
	-Group practice prepayment plans for whom EI numbers are used in coding the ID field -GPPP's for whom EI numbers are not available and the carrier's own physician/supplier code has been assigned
13. Assignment Decision	-Assignment accepted -Assignment not accepted All covered expenses applied to deductible
14. Carrier Number	The number assigned by HCFA to each carrier's service area
15. Intermediary Control	The unique control number which is assigned by the carrier to the individual bill. This code will generally be the same number as that assigned to corresponding payment records or (where no payment record is prepared, i.e., deductible not met) the query.
16. Type of Request for Payment	-HCFA-1490, 1490W, 1490U, 1491, 1500 -HCFA-1556

	Information	Description
17.	Cancel Indication	All initial records are blank in this position. If a Summary Record has been submitted which should never have been prepared, i.e., services were subsequently disallowed, an identical record is submitted containing a 1 in this position.

NOTE: The appropriate fields below (18-22) are completed for each separate service or separate group of services (up to a maximum of 18). When a number of separate services or separate group of services is less than 18, the remainder of the record is filled with blanks.

18.	Type of Service Code	This field denotes the type of service that the remaining fields (19-22) represent: -Medical care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic laboratory -Radiation therapy -Anesthesia -Assistance at surgery -Other medical services -Charges for whole blood or packed red blood cells -Purchase of used DME -Surgical second opinion -Surgical third opinion -Alternate payment method for maintenance dialysis -Live kidney donor -ASC facility usage -Renal supplies in the home -Pneumococcal Vaccine

Information

Description

The following definitions of type of service are used in assigning the codes:

Medical Care - Includes all physician services, including those of podiatrists, surgical chiropodists and chiropractors not elsewhere classified, and office visits, home visits, and nonsurgical hospital visits. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are also included. Consultation is excluded.

Surgery - Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and services pertaining to incision, excision, repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation and endoscopy

Consultation - Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the evaluation and/or treatment of a patient

Diagnostic X-Ray - X-Ray and related services undertaken for diagnostic purposes

Clinical Laboratory - Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Also includes certain mechanical or machine tests such as EKG, EEG, BMT, etc.

Radiation Therapy - Therapeutic services, such as X-Ray, radon, radium, and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, angiomas, vascular nevi, lymphomas, leukemia and thyroid disease

Exhibit A

Information	Description
	Anesthesia - Services for anesthesia including the appropriate pre and post-operative visits, administration of anesthetic, and transfusion of fluid and/or blood incident to the anesthesia or surgery
	Assistance at Surgery - Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such services prescribed by the carrier
	Other Medical Services - Services falling in the following special categories: -Rental, purchase or repair of durable medical equipment -Internal and external prosthetic devices and appliances -Supplies -Ambulance services
	Charges for Whole Blood or Packed Red Blood Cells - Includes bills where the charges are for whole blood or packed red blood cells and where reimbursement is made
	Purchase of Used Durable Medical Equipment - Effective November 1977 specific carriers were authorized to reimburse beneficiaries/suppliers 100 percent of the reasonable charge for purchase of used DME if such charge does not exceed 75 percent of the cost of new DME (Deductible must still be met)
	Surgical Second Opinion - Effective March 1978 carriers were authorized to pay claims for patient-initiated second physician opinions pertaining to the medical need for surgery. Beneficiaries are responsible for applicable deductible and coinsurance amounts.

Information	Description
	Surgical Third Opinion - Effective March 1978 carriers are also authorized to pay claims for patient-initiated third physician opinions pertaining to the medical need for surgery. Beneficiaries are responsible for applicable deductible and coinsurance amounts. Third opinion requests may occur if the initial and second physician opinions differ regarding the medical need for such surgery.
	Alternate Payment Method for Maintenance Dialysis - Effective July 1975 physicians may elect to be paid on a monthly basis for all services rendered to maintenance dialysis patients
	Physicians Services Provided to Living Kidney Donors - Effective October 1978, carriers were authorized to pay claims for physician services rendered to obtain a kidney from a living donor. Services include monies for both the kidney donation surgery and post operative recovery period. These claims are paid under the name and HI claim number of the recipient.
	ASC Facility Usage - Effective September 1982, carriers were authorized to reimburse Ambulatory Surgical Centers for 100% of their cost of facility usage for Medicare beneficiaries
	Renal Supplies in the home - Cost of supplies used in the beneficiary's home in the treatment of end stage renal disease
	Pneumococcal Vaccine - Effective July 1, 1981, carriers were authorized to reimburse beneficiaries/physicians 100 percent of the reasonable charge of the cost and administration of pneumococcal vaccine

Exhibit A

Information	Description
19. Place of Service Code	This field denotes the place of service: -Office -Home -Inpatient hospital -Outpatient hospital -Skilled nursing facility -Independent laboratory -Independent Kidney Disease Treatment Center -Ambulatory Surgical Centers -Other Note: Outpatient hospital code is used for services in a clinic which is part of a hospital. Office code is used for all other clinics.
20. Service Charge	The total charges for each separate service or group of services
21. Service Reasonable Charge	The total reasonable charge for each separate service or group of services
22. Number of Services	This field is completed only for types of service code other than blood. If type of service code is blood, this field is not coded. A service is defined as a procedure having a separate reasonable charge determination. One service is coded 01. If two or more identical services are being combined, the total number of services is entered, i.e. 02 thru 99.
23. Additional Type and Place of Service	All fields from "Type of Service code-18" through "Number of Services-22" are repeated for up to 18 different types of service-place of service combinations Note: Where the number of separate combinations is greater than 17, the remaining combinations are aggregated and coded with type of service based on the largest allowed charge of all the remaining services. The place of service is left blank.

IX. Medicare History Sample File

Introduction

The Health Insurance System provides for processing and maintenance of all utilization health insurance bills and payment records, and enrollment records. As a by-product of this system, individual HCFA statistical files are obtained to provide data bases for all types of information on the health insurance program. However, until the implementation of the Medicare History Sample all requests for person data over a time period of more than a single year had to be processed by combining various individual files. A more efficient method of obtaining hospital and medical insurance data is to create a sample file consisting of selected fields from the various Medicare bill files on an ongoing scheduled basis. Such a file permits more in-dept studies of utilization patterns over extended time periods.

The Medicare History Sample file is intended to provide a more efficient access to person data on a longitudinal basis. This file, being a combined file and having annual updates, has eliminated the problem of having to refer to old files with old formats. Information for all years (representing services after 1973) are consistent and fully documented, and contained in this one file.

Preparation of Medicare History Sample (MHS) File

The MHS file is prepared on a five percent sample person basis for years 1974 and later and provides a combined record of all Medicare activity for each year. Selection of beneficiaries to be included in this file is based on the ever-enrolled (1974 and later) concept. Thus, beneficiaries enrolled in the Medicare program after 1973, regardless of utilization activity, are represented in this file. Selected personal characteristics are obtained from both the active and inactive HISKEW files. Utilization data for each year are selected from inpatient hospital, SNF, home health agency and outpatient bills that are processed by Medicare intermediaries, and physician service information is obtained from payment records that are processed by Medicare carriers.

Each portion obtained is then combined to form one record for each Medicare beneficiary within the sample on an ongoing basis. Once a beneficiary is included in the MHS sample that person remains on the file regardless of activity or death. This provides the flexibility for ready access of person data needed to follow utilization patterns of each sample beneficiary.

The initial selection of beneficiaries included in this sample file was based on records obtained from the active and inactive HI Master Enrollment Record as of the update closest to April 1, 1975, with the following characteristics:

1. Primary and/or cross-reference HI claim number in the 5 percent sample.

2. Current entitlement to hospital insurance benefits (Part A) and/or supplementary medical insurance benefits (Part B) was before January 1, 1975, without current termination before January 1, 1974; i.e., anyone ever enrolled in 1974.

Subsequent updates of additional beneficiaries will continue to be based on entitlement after 1973 and will be obtained annually from the updated Master Enrollment File. In addition to newly entitled beneficiaries, those previously included are reselected from subsequent years' enrollment file for use in a current update. This provides the MHS file with current demographic characteristics. An annual segment is appended to the Master Record portion of all active beneficiaries and provides the means for noting changes in benefit status, residency, and type of enrollment. The status and coverage characteristics are based as of July 1 of the reference year.

All sample utilization records (bills and payment records) included in the initial preparation of the MHS were selected from records processed through June 1975 with services in 1974.

Subsequent annual updates to the MHS included those initial debit utilization records with service dates after December 31, 1973, processed since the prior years' file through the current years' June update. Thus, when accreting for 1980 activity, only sample records with service dates of 1974-1980 and processed through June 1981 are used. The types of utilization records used to obtain information are as follows:

1. Stay Records

   a. Inpatient hospital stay records representing complete stays sequenced by date of discharge.

   b. Inpatient SNF stay records representing complete stays or incomplete stays.

The incomplete SNF stay record is replaced in subsequent updates by a complete stay record when the discharge record for that stay has been processed. Effective with the 1979 update, SNF stays are sequenced by date of admission.

Multiple inpatient hospital or SNF stays for the year are included in the file.

2. Home health agency, outpatient, and payment records are summarized by type of record on a calendar year basis and included in the annual update of the MHS.

Two additional source files are used to annotate the MHS sample records with information relating to third party and GPPP activity. These data are obtained from the State Buy-In and GPPP member files annually, and identify those MHS beneficiaries ever enrolled in the reference year as a State Buy-In and/or a member of a GPPP.

Contents of the MHS Record

The complete MHS record varies in size, based on whether Medicare utilization is present or not, type of service utilized by the beneficiary, and the number of years involved. The file is maintained in chronological sequence by type of record and by date(s) of service. Exhibit A details each possible type of service present for a MHS beneficiary.

Volume Statement

Approximately 1,600,000 individual HISKEW accounts are represented on the Medicare History File. In addition, the individual sections contain the following number of records:

1. Annual Demographic Section - A demographic record is added each year the enrollee is alive. Approximately 1,300,000 records were initially established in 1974. Subsequent years have added approximately 1,400,000 records annually.

2. HHA, Outpatient and Payment Records - An annual record is added for each type of service used during the year. The approximate numberof records added each year are shown below:

   a. HHA - 35,000
   b. Outpatient - 350,000
   c. Payment Records - 700,000

3. Inpatient and SNF Records - All stay records are added to the account as they become available. The approximate number of records added each year are shown below:

   a. I/P - 450,000
   b. SNF - 20,000

Exhibit A

Medicare History Sample Record Contents

Fixed Demographic Section

Information	Description
1. Type of Record	Blank
2. HI Claim Number 1/	Beneficiary's Health Insurance claim number
a. Account Number b. Equatable BIC Code	
3. Cross-Reference Claim Number 2/	
a. X-R Account No.	Blank if no cross-reference number
b. X-R BIC Code	
4. Status of HIC Number 2/	- Current number in 5% sample--no cross-reference - Both current and cross-reference numbers in 5% sample - Current number in 5% sample. Cross-reference not in sample. - Cross-reference in 5% sample. Current number not in sample. NOTE: For records with the current HI claim number not in the sample, the cross-reference number is placed in the current HI claim number field, while the cross-reference claim number field contains the actual current number.

Exhibit A

Information	Description
5. Dual Entitlement 2/	-No -Yes
6. Date of Birth	Year and Julian date of beneficiary's birth
7. Sex Code	-Male -Female -Unknown
8. Race	-White -Black -Other -Unknown
9. Part 'A' Dates 2/	Year and Julian date
a. Latest entitlement	
b. Latest termination	
c. Prior entitlement	
d. Prior termination	
10. Reason for Latest Part 'A' termination	-No termination -Death -Non-payment of premium -Voluntary withdrawal -Entitled under another number -DIB recovery
11. Part 'B' Dates 2/	Year and Julian date
a. Latest entitlement	
b. Latest termination	
c. Prior entitlement	
d. Prior termination	
12. Reason for Latest Part 'B' Termination 2/	- No termination - Death - Non-payment of premium - Voluntary withdrawal - Entitled under another number - DIB recovery

Exhibit A

	Information	Description
13.	Date of Death 2/	Year and Julian date of beneficiary's death
14.	Original Reason for Entitlement	-OASI -DIB -RENAL -DIB & RENAL
15.	End Stage Renal Disease Indicator	Coded to indicate method of original notice of ESRD -MBR Notice of ESRD -HI Notice of ESRD -NIH Notice of ESRD -MBR and HI Notice of ESRD -MBR and NIH Notice of ESRD -HI and NIH Notice of ESRD -MBR, HI and NIH Notice of ESRD

Exhibit A

Annual Demographic Section 3/

	Information	Description
1.	Type of Record	Constant '*'
2.	Reference Year	YY
3.	Current Reason for Entitlement	-OASI -DIB -Renal -Both DIB & Renal
4.	Medicare Coverage 4/	-No coverage or Dead (include beneficiaries whose start date(s) is after reference year) -Part A entitlement only -Part B entitlement only -Both Part A and Part B
5.	Medicare Status Code 4/	-Aged only-no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
6.	Insured Status 5/	-Uninsured -Insured
7.	State and County Code of Residence	SSA Geographic Code Book Publication 026
8.	ZIP Code of Residence	Actual
9.	GPPP Plan Number	Blank if no GPPP plan. Obtained from G.P.P.P. Master file.
10.	State Welfare Buy-In	-State Welfare Buy-In -No State Welfare Buy-In. Obtained from Third Party Master File

Exhibit A

HHA Section 6/

Information	Description
1. Type of Record	Constant 'A'
2. Reference Year	YY. Obtained from "Ending Date of Service" fields.
3. Part 'A' Totals 7/	Based on plan code "p" Part A services. Totals accumulated for the year.
a. Visits	
b. Charges	
c. Other Service Charges	Obtained by subtracting charges (A-I) from charges (A-K), Form HCFA-1487
d. Reimbursement Amount	
4. Part 'B' Totals 7/	Based on plan code "M" Part B services. Totals accumulated for the year.
a. Visits	
b. Charges	
c. Other Service Charges	Charges (A-K) less charges (A-I), Form HCFA-1487
d. Reimbursement Amount	
5. Patient Status Indicator (Based on the record having the latest status date in the reference year)	-Discharged alive -Died -Still receiving benefits -Visits exhausted
6. Patient Status Date (Based on the record having the latest status date in the reference year)	Julian day

Exhibit A

Outpatient Section 6/

	Information	Description
1.	Type of Record	Constant 'B'
2.	Reference Year	YY. Obtained from "Date of Last Service" field.
3.	Outpatient Services	Based on third position of provider number equaling 0, 2, 3, or 4 and type of service code is a 2 (O/P Type). Totals accumulated for the year.
	a. Number of Bills	
	b. Covered Charges	
	c. Reimbursement Amount	
4.	Inpatient Services	Based on third position of provider number equaling 0, 2, 3, or 4 and type of service code is a 1 (I/P Type). Totals accumulated for the year.
	a. Number of Bills	
	b. Covered Charges	
	c. Reimbursement Amount	
5.	Other Services	Based on all other combinations of third position of provider number and type of service code. Totals accumulated for the year.
	a. Number of Bills	
	b. Covered Charges	
	c. Reimbursement Amount	

Exhibit A

Payment Record Section 6/

Information	Description
1. Type of Record	Constant 'C'
2. Reference Year	YY. Obtained from "Last Expense Date" field.
3. Non-Hospital Based Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1490, 1556. Totals accumulated for the year.
a. Number of Records	
b. Reasonable Charges 8/	
c. Reimbursement Amount	
4. Physician Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1490, 1556 and with specialty codes 01-40, 48, 49, 70 or 99. Totals accumulated for the year.
a. Number of Records	
b. Reasonable Charges 8/	
c. Reimbursement Amount	
5. Surgical Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1490, 1556 and with specialty codes 01-40, 48, 49, 70 or 99 and with type of service code 2. Totals accumulated for the year.
a. Number of Records	
b. Reasonable Charges 8/	
c. Reimbursement Amount	

Information	Description
6. Supplier Services	Based on totals accumulated from records with payment codes 0/T 4 or 5 and with specialty codes 51-69, 87 or 88. Totals accumulated for the year.
a. Number of records b. Reasonable Charges 8/ c. Reimbursement Amount	
7. Hospital Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1554. Totals accumulated for the year.
a. Number of Records b. Reasonable Charges 8/ c. Reimbursement Amount	
8. Psychiatric Charges	Accumulated total for the year
9. Unassigned Totals	Based on totals accumulated from records with payment code indicating payment made to beneficiary. Totals accumulated for the year.
a. Number of Records b. Reimbursement Amount	

Exhibit A

Inpatient Hospital Stay Section 6/

	Information	Description
1.	Type of Record	Constant 'D'
2.	Reference Year	YY-Year from field
3.	Date of Admission	Year and Julian date of admission in this stay
4.	Provider Data	
	a. Number	Identification number of the provider submitting the claim
	b. Type	-Short-stay -Long-stay -TB -Psychiatric -Christian Science -Emergency -Federal -Other
5.	Date Benefits Exhausted	Year and Julian date
6.	Number of Covered Days	Includes lifetime reserve days
7.	Discharge Data	
	a. Status	- Alive--no surgical indicator - Dead--no surgical indicator - Benefits Exhausted--no surgical indicator - Alive--surgical indicator - Dead--surgical indicator - Benefits Exhausted--surgical indicator

Information	Description
b. Date	Year and Julian date of discharge
c. Principal Diagnosis Code	ICD-9-CM, Volumes I and II for 1979 and later; ICDA-8 for 1978
d. Additional Diagnosis Indicator	-No additional diagnosis -Additional diagnosis -Unknown additional diagnosis
e. Source Code	Indicates where the diagnosis was coded - Provider - HCFA (Central Office)
8. Surgical Data	
a. Date	Year and Julian date of surgery
b. Principal Surgery Code	ICD-9-CM, Volume III for 1979 and later; CPT for 1978
c. Additional Procedure	-No surgery involved -No additional procedure -Additional procedure -Unknown additional surgical procedure
d. Source Code	Indicates where the surgery code was obtained -Provider -HCFA (Central Office)
9. Totals	Dollars Only
a. Charges b. Non-Covered Charges c. Deductions d. Reimbursement Amount	
10. Lifetime Reserve Days	Number of lifetime reserve days used in this stay
11. Coinsurance Days	Number of coinsurance days used in this stay

Information	Description
b. Date	Year and Julian date of discharge
c. Principal Diagnosis Code	ICD-9-CM, Volumes I and II for 1979 and later; ICDA-8 for 1978
d. Additional Diagnosis Indicator	-No additional diagnosis -Additional diagnosis -Unknown additional diagnosis
e. Source Code	Indicates where the diagnosis was coded - Provider - HCFA (Central Office)
8. Surgical Data	
a. Date	Year and Julian date of surgery
b. Principal Surgery Code	ICD-9-CM, Volume III for 1979 and later; CPT for 1978
c. Additional Procedure	-No surgery involved -No additional procedure -Additional procedure -Unknown additional surgical procedure
d. Source Code	Indicates where the surgery code was obtained -Provider -HCFA (Central Office)
9. Totals	Dollars Only
a. Charges b. Non-Covered Charges c. Deductions d. Reimbursement Amount	
10. Lifetime Reserve Days	Number of lifetime reserve days used in this stay
11. Coinsurance Days	Number of coinsurance days used in this stay

Exhibit A

Information	Description
10. Totals	Dollars Only
a. Charges	
b. Covered Charges	
c. Coinsurance Amount	
d. Reimbursement Amount	
11. Total Estimated Charge Indicator	-No -Yes
12. Coinsurance Days	Total number of coinsurance days used in the stay

Exhibit A

FOOTNOTES

1/ See Exhibit B.

2/ If necessary, recoded, during each annual update.

3/ The annual portion will be present for each year account is active. Data are obtained during each annual update and represent status as of the input cut-off date.

4/ As of July 1 of Reference year.

5/ Any beneficiary with the first position of the original BIC code J, K, M, or T is considered as uninsured.

6/ All money fields are rounded to the nearest dollar.

7/ Parenthetical characters refer to corresponding letters of Form HCFA-1487, HHA Billing Report.

8/ Reasonable charges are the sums of psychiatric charges plus medical charges.

9/ All benefits exhausted stays (no discharge record) are replaced when the complete stay becomes available. Substitution for a complete stay is made based on match of HI claim number,date of admission and provider number.

Equatable BIC Code

The MHS current HIC number consists of two parts: (1) the account number which is a 9 position numeric field and (2) the Beneficiary Identification Code (BIC) which indicates the type of beneficiary involved. Since the beneficiary's status may change (e.g., wife becomes a widow) it is necessary to recognize similar BIC's so that the combining of the various files will not create multiple records for the same account. An equatable BIC routine, developed for this purpose, is described below.

When matching the current HIC number from the administrative records to the HISKEW, all records must match on the entire HIC number field. However, records with identical initial 9 positions but with different BIC codes are considered as equal if the original unequal BIC code is equatable within each of the following groups:

A. In the following table of equatable BICs used in the MHS project the SSA and RRB BICs are divided into categories. All BICs in one category are equatable to one another within that category. BIC codes other than those shown stand alone, i.e., no equatable routines are involved.

1. SSA CATEGORIES

CATEGORY	BICs
1	A; J1; J2; J3; J4; M; M1; T
2	B; B2; B6; D; D4; D6; E; E1; K1; K2; K3; K4
3	B1; D1; D5; E4; E5

2. RRB CATEGORIES

	BICs
1	10; 80
2	11; 13; 14; 16; 43; 46; 83; 84; 86

X. Special Purpose Files

Introduction

This chapter describes several special purpose files which are created for specific projects. These files are created from the detailed billing records and are used to prepare annual publication tabulations and research notes.

Health Insurance Bill Skeleton File for State and County Reimbursement Publication (Exhibit A)

This file is used to create an annual publication: Reimbursement by State and County. This is an annual Medicare publication with reimbursement amounts based on the year claims are approved for payment by intermediaries or carriers.

The file is created by writing off selected information from each detailed billing and payment record processed by HCFA. The write-off occurs weekly.

Approximately 193,000,000 records are involved annually.

State and County Reimbursement Publication File - (Exhibit B)

This file contains the tabulated State and county data in the publication format used by the system for automated tabular composition.

For each year, the data are compiled based on an 18-month period. The period begins with the first month of the file year and continues until the cutoff date, 6 months after the file year. Bills for years with claim approved prior to the most current year being tabulated are also included in the current year's file. For example, the 1981 annual file contains all bills approved for payment in 1981 that were processed in HCFA during the period January 1981 through June 1982. Also included are bills approved for payment in 1980 or earlier, processed after June 1981, that were not included in the 1980 file.

Each record is identifiable by table number and line item. The records contain calendar year enrollment and reimbursement data for Health Insurance and/or Supplementary Medical Insurance, Health Insurance, and Supplementary Medical Insurance covered services. The records are tabled by each Medicare status code for region, division, and State tables, aged and disabled for metropolitan/nonmetropolitan tables and for State and county tables giving detailed data for each line item.

The reimbursement amount is the total payment made during the publication calendar year for covered services provided to the beneficiary in the publication year or prior years. Excluded from the reimbursement amount are administrative costs, deductibles, co-payment amounts and charges for non-covered services. Also excluded are supplementary medical insurance reimbursements to group practice prepayment plans and health maintenance organizations dealing directly with HCFA. However, beneficiaries enrolled in these plans are included in the publications' enrollment counts.

Approximately 9,500 print records annually are involved.

Georgaphic Index Publication File (Exhibit C)

This file contains the index data in the publication format used by the system for automated tabular composition. Each record is identifiable by table number and line item. The data are tabulated for Health Insurance and Supplementary Medical Insurance by: geographic index, age-sex index, reimbursement per enrollee, and adjusted reimbursement per enrollee for States, county, and metropoloitan-nonmetropolitan counties.

The geographic index is the ratio of a specific area's per capita reimbursement to the "all areas" per capita reimbursement after both figures are age-sex adjusted. The age-sex index is the ratio of differences in reimbursement per enrollee purely because of differences in the distribution of enrollees by age and sex. Reimbursement per enrollee is determined by dividing the specific area's reimbursement (obtained from the "State and County Reimbursement" publication) by the mid-year enrollment for the year being processed. The adjusted reimbursement per enrollee is the quotient of dividing the reimbursement per enrollee by the age-sex index.

Approximately 5,000 print records are involved.

Person Summary File (Exhibit D)

The file is used to create the annual Medicare Summary Publication based on persons receiving reimbursed Medicare services in a year. For each year, data are compiled based on a 21 month period. The period begins with the first month of the file year and continues until the cutoff date, nine months after the file year. Separate files for Inpatient, Skilled Nursing Facility, Home Health Agency-Part A and Part B, Outpatient Bills and Payment Records are created from the detailed bill records that contain reimbursement amounts. Bills without reimbursement are not included. Data for aged persons are based on the billing records of a five percent sample of beneficiaries, and for disabled persons are based on the billing records of a 40 percent sample of beneficiaries. For years prior to 1980, the disabled person file was based on 100 percent of the billing records.

Each of the selected files is sorted individually and then merged to produce an aged file and a disabled file. These two files are summarized separately, by person, to bring together all reimbursed services for that person during the year. As an example, the 1981 Person Summary File is created from all bills with dates of service in 1981 and with amounts reimbursed greater than zero that were processed in HCFA during the period January 1981 through September 1982. Note that this file is based on year service incurred, while the State and County Reimbursement File (described above) is based on year claim approved.

Approximately 2,225,000 records are involved annually.

Provider Summary File

This file contains summarized data on Medicare bill activity for each institutional provider. These utilization bills are summarized monthly by provider number, year and month of through date, and bill type, i.e., Forms HCFA-1453, 1486 and Discharge Notices (Non-Covered Bills). Data summarized include number of discharges and days of care by type of beneficiary (aged or disabled) and by vital status (alive or dead). In addition, length of stay intervals are aggregated for each summary record.

Approximately 215,000 records are created annually.

Outpatient Bill Skeleton File (Exhibit F)

This file is prepared annually for a 5 percent sample of HCFA-1483 bills--Provider Billing for Medical and Other Health Services. For each service year the file is prepared from all bills processed by HCFA through the period ending 12 months after the end of the service year. For example, the 1981 file is prepared from all outpatient bills processed through December 1982 having a date of service in 1981.

Approximately 1,050,000 records are involved annually.

Home Health Agency Skeleton File (Exhibit G)

This file is prepared annually for a 40 percent sample of HCFA-1487 bills--Home Health Agency Report and Billing. For each service year the file is prepared from all bills processed by HCFA through the period ending 12 months after the end of the sevice year. For example, the 1981 file is prepared from all HHA bills processed through December 1982 having a date of service in 1981.

Approximately 1,200,000 records are involved annually.

Exhibit A

Health Insurance Bill Skeleton File
For State And County Reimbursement Publication

	Information	Description
1.	Record Identification Code	-Part B Payment Record -Part A Bill -Part B Bill other than Payment Record
2.	HI Claim Number	Beneficiary's Health Insurance claim number
3.	State Code of Residence	SSA geographic code book Publication 026
4.	County Code of Residence	SSA geographic code book Publication 026
5.	Date of Birth	Year and Julian date of beneficiary's birth
6.	Sex	-Male -Female -Unknown
7.	Race	-White -Black -Other -Unknown
8.	Format (Payment Record)/Form (Other than Payment Record)	Source of Information: For Payment Records -New Format -Old Format For other than Payment Records -Inpatient -Outpatient -Christian Science -Home Health -Nonpayment Bills (1453, 1486, 1487)
9.	Entry Code (Payment Record)/Query Code (Other than Payment Record)	A code for type payment record being submitted: -Original debit -Supplemental -Full credit

Information	Description
9. Continued	-Partial credit -Replacement debit -Partial debit -Correction record acknowledges full overpayment; also acknowledges an A reject previously submitted -Correction record acknowledges partial overpayment Code indicating status of bill other than payment records: -Interim Bill -Visits Exhausted (HHA) -Final Bill -Discharge Notice (Non-covered Bill) -Debit Adjustment -Credit Adjustment
10. Recode Code (Payment Record)/Transaction Code (Other than Payment Record)	Code indicating that a payment record is an initial submittal, a resubmittal, an initial reject, or a resubmitted reject: -Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records Codes for records other than payment record indicating type of facility: -Christian Science SNF -Psychiatric Hospital Facility -Tuberculosis Hospital Facility -General Care Hospital Facility -Regular SNF -HHA -Outpatient

Exhibit A

	Information	Description
11.	Date Paid (Payment Record)/Date Approved (Other than Payment Record)	Year and Julian Date
12.	Reimbursement Amount	
13.	Medicare Status Code	-Aged only, no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
14.	Current Reason for HI Entitlement	-OASI -DIB -Renal
15.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
16.	ESRD-DIB Data Indicator	-All Off -ESRD Spouse or Child of Worker -Prior Unqualifying DIB -Both Conditions Present
17.	ZIP Code of Residence	Actual
18.	Date of Service	Year and Julian Date date service incurred
19.	Place of Service	(Payment Records only - blank filled for Bills) -Office -Home -Inpatient Hospital -SNF/Nursing Home -Outpatient Hospital -Independent Laboratory -Other -Independent Kidney Disease Treatment Center

	Information	Description
20.	Type of Service	(Payment Records only - blank filled for Bills) -Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Charges for whole blood or packed red blood cells -Purchase or rental of used DME (eff. 11/77) -Surgical second opinion (eff. 03/78) -Surgical third opinion (eff. 03/78) Blank for per diem records -Alternate payment method for maintenance dialysis -Live kidney donor
21.	Carrier Number and ODR Indicator (Payment Records) Provider Number (Other than Payment Records)	For Payment Records: Carrier Number. For bills other than Payment Records: Provider Number shown on Bill.
22.	Total Charges	Total Charges. (For Payment Records this field is the sum of Medical Charges plus Psychiatric Charges)
23.	Total HHA Visit Charges	(HHA bills only. Zero filled for other Bill types and Payment Records). Total charges for HHA visits.
24.	Total Inpatient Days of care/Total HHA Visits	(Inpatient, SNF, HHA, and Non-Covered Inpatient Bills only. Zero filled for Outpatient and Non-covered HHA Bills and Payment Records). Inpatient Hospital Days of Care/Home Health Agency Visits.

Exhibit A

Information	Description
25. Inpatient Covered Days	(Inpatient, SNF, and Non-Covered Inpatient Bills only. Zero filled for other Bill types and for Payment Records). Number of covered days.
26. HHA Plan Code	(HHA Bills only. Blank filled for other Bill types and Payment Records, except for Non-covered HHA Bills which are force coded 'P'). Type of Bill -Part A -Part B
27. Service From Date	(Bills only. Zero filled for Payment Records). Year and Julian beginning date of stay or service.
28. Patient Status	(Inpatient, SNF, HHA, and Non-covered Bills only. Blank filled for Outpatient Bills and Payment Records). -Discharged -Died -Still Patient -Visits Exhausted
29. Specialty Code	(Payment Records only. Blank filled for Bills). Physician or Supplier Specialty Code.
30. Date of Admission	Year and Julian date of admission. Inpatient and SNF Bills only. Zero filled for other bill types and Payment Records.
31. Length-of-Stay	Number of days from date of admission through date of service. Not computed for Interim Bills. Inpatient and SNF Bills only. Zero filled for other bill types and Payment Records.

Exhibit B

State and County Reimbursement Publication Record

Information	Description
1. Table Number	Actual Table Number
2. Record Number	Identifies type of record for each table State Tables: All Areas United States Region Division State Metropolitan - Nonmetropolitan Tables United States State State - County Tables: State County
3. Region Code	Identifies record by region for each table State Tables: Northwest North Central South West Residence Unknown Outlying Areas, Foreign Countries Metropolitan - Nonmetropolitan Tables: Not used State - County Tables: Not used

Exhibit B

Information	Description
4. Division Code	Identifies record by division for each table State Tables: New England Middle Atlantic East North Central West North Central South Atlantic East South Central West South Central Mountain Pacific Metropolitan - Nonmetropolitan Tables: Not used State - County Tables: Not used
5. Sequence Code	Puts State records in proper sequence within geographic division for State tables. Not used in other tables.
6. State Code	Identifies State records in each table State Tables: All Areas United States Region Division State Metropolitan - Nonmetropolitan Tables: United States State Metropolitan County with Central City Metropolitan County without Central City Nonmetropolitan County State-County Tables: State County

Exhibit B

	Information	Description
7.	County Code	Identifies county records in each table State Tables: Not used Metropolitan - Nonmetropolitan Tables: United States State Metropolitan County with Central City Metropolitan County without Central City Nonmetropolitan County State - County Tables: State County
8.	Record Type	Constant
9.	Edit Control	Edit characters used by System for Automated Tabular Composition program Numeric Whole Number, Suppress Zeros Dollars and Cents, Suppress Zeros Dollars and No Cents
10.	Total Enrollment, Parts A and/or B	Mid-year enrollment as of March of the following year
11.	Total Reimbursement, Parts A and/or B	Total amount reimbursed during the year
12.	Average Reimbursement, Parts A and/or B	Average reimbursement per enrollee
13.	Total Enrollment, Part A	Mid-year enrollment as of March of the following year

Exhibit B

	Information	Description
14.	Total Reimbursement, Part A	Amount reimbursed during the year
15.	Average Reimbursement, Part A	Average reimbursement per enrollee
16.	Total Enrollment, Part B	Mid-year enrollment as of March of the following year
17.	Total Reimbursement, Part B	Amount reimbursed during the year
18.	Average Reimbursement, Part B	Average reimbursement per enrollee

Exhibit C

Geographic Index Publication Record

Information	Description
Table Number	Actual number of table
Record Indicator 1	Record identifier for each table Table 1: All areas United States Region Division All Others Tables 2 and 3: United States Puerto Rico
Record Indicator 2	Record identifier for each table Table 1: All Areas United States Region Tables 2 and 3: State
Record Indicator 3	Record identifier for each table Table 1: All Areas United States Region Division Tables 2 and 3: United States State County

Exhibit C

Information	Description
Record Indicator 4	Record identifier for each table Table 1: All Areas United States Region Division State Tables 2 and 3: Standard Metropolitan Statistical Area
Date	Four digit year
HI-GI	Geographic index for health insurance, rounded
HI-ASI	Age-sex index for health insurance, rounded
HI-R	Reimbursement per capita for health insurance, rounded
HI-RR	Adjusted reimbursemenmt per capita for health insurance, rounded
SMI-GI	Geographic index for supplemental medical insurance, rounded
SMI-ASI	Age, sex index for supplemental medical insurance, rounded
SMI-R	Reimbursement per capita for supplemental medical insurance, rounded
SMI-RR	Adjusted reimbursement per capita for supplemental medical insurance, rounded

Exhibit D

Person Summary File

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	State Code	SSA geographic code obtained from Master Record indicating State of beneficiary's residence
3.	County code	SSA code obtained from Master Record indicating county of beneficiary's residence
4.	Medicare Status Code	Aged only - No ESRD Aged with ESRD Disabled without ESRD Disabled with ESRD ESRD only
5.	Renal Insurance Status Indicator	Worker Other
6.	Beneficiary Status	OASDI RRB Dual
7.	Date of Birth	Beneficiary's date of birth
8.	Date of Death	Beneficiary's date of death
9.	Race	White Black Unknown
10.	Sex	Male Female
11.	Age	Age at last birthday as of 07/01/YY if alive at end of year. For aged age 64 consider as age 65. For disabled age 65, consider as age 64. For persons who died, use age on first day of month of death.

Exhibit D

	Information	Description
12.	Patient Status	-Discharged (alive) -Died -Still patient

Reimbursement Amounts (Dollars and Cents)

13. Inpatient Hospital

14. Skilled Nursing Facility

15. HHA-Part A

16. Physician and Other Medical Services

17. Outpatient

18. HHA Part B

19. Total Part A

20. Total Part B

21. Total Part A and/or Part B

22. Part A and Part B

23. Part A only

24. Part B only

Exhibit E

Provider Summary Record File

Information	Description
1. Provider Number	Six position number identifies a provider. First two positions are the State code. Positions 3 and 4 identify a specific facility. Positions 5 and 6 are numeric except for emergency and Federal hospitals which are coded E and F respectively, in the 6th position.
2. Type of Facility	-Hospital -Skilled Nursing Facility -Christian Science Sanatorium -Home Health Agency -Other
3. Bill through date	Ending date or discharge date shown on bill (YR-MO)
4. Discharge Data	Data below apply only to discharges from Forms HCFA-1453, HCFA-1486, and Discharge Notices (Non-Covered Bills)
a. Aged	Data for beneficiaries who are aged: -Number of Discharges - alive -Number of Days of care - alive -Number of Discharges - dead -Number of Days of care - dead
b. Disabled	Data for beneficiaries who are disabled: -Number of Discharges - alive -Number of Days of care - alive -Number of Discharges - dead -Number of Days of care - dead

Exhibit E

Information	Description
5. Length of Stay Intervals	Number of discharges by interval and type of facility Counts below apply only to discharges from Forms HCFA-1453, HCFA-1486, and Discharge Notices (Non-Covered Bills)
a. LOS Interval (1)	0-1 day discharges if short-stay 0-15 day discharges if long-stay 0-25 day discharges if SNF
b. LOS Interval (2)	2-3 day discharges if short-stay 16-30 day discharges if long-stay 26-50 day discharges if SNF
c. LOS Interval (3)	4-7 day discharges if short-stay 31-60 day discharges if long-stay 51-75 day discharges if SNF
d. LOS Interval (4)	8-10 day discharges if short-stay 61-90 day discharges if long-stay 76-100 day discharges if SNF
e. LOS Interval (5)	11-14 day discharges if short-stay 91-120 day discharges if long-stay 101-150 day discharges if SNF
f. LOS Interval (6)	15-21 day discharges if short-stay 121-150 day discharges if long-stay 151-300 day discharges if SNF
g. LOS Interval (7)	22-40 day discharges if short-stay 151-180 day discharges if long-stay 301-365 day discharges if SNF

Exhibit F

Outpatient Bill Skeleton Record-5% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Date of Birth	Year and Julian date of beneficiary's birth
3.	Sex	-Male -Female -Unknown
4.	Race	-White -Black -Other -Unknown
5.	State Code	-SSA geographic code obtained from Master Record indicating State of beneficiary's residence
6.	County Code	-SSA geographic code obtained from Master Record indicating county of residence
7.	ZIP Code of Residence	-Actual
8.	Medicare Status Code	-Aged only - no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim
10.	Type of Service	-Inpatient -Outpatient -Other
11.	Nature of Illness	Diagnostic code assigned from ICD-9-CM, Volumes I and II
12.	Additional Diagnosis Indicator	-No -Yes -Unknown

Exhibit F

	Information	Description
13.	Surgical Procedure Code	Code assigned from ICD-9-CM, Volume III
14.	Additional Surgery Indicator	-No -Yes -Unknown
14.	Number of Clinic Visits	Actual number
16.	Number of Emergency Room Visits	Actual number
17.	Covered Charges	Covered charges for each service: Clinic Visits Emergency Room Laboratory Radiology Pharmacy Blood Ambulance Physical Therapy Total Others
18.	Total Covered Charges	Total covered charges for above services
19.	Date of Last Service	Year and Julian date of last service
20.	Amount Reimbursed	An interim payment made to the institution. Final reimbursement is made on a cost basis based on the cost report each institution is required to prepare at the end of their fiscal year.

Exhibit G

Home Health Agency Skeleton Record-40% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Date of Birth	Year and Julian date of beneficiary's birth
3.	Sex	-Male -Female -Unknown
4.	Race	-White -Black -Unknown
5.	State Code	SSA Geographic code obtained from HI Master Record indicating State of beneficiary's residence
6.	County Code	SSA Geographic code obtained from HI Master Record indicating county of beneficiary's residence
7.	ZIP Code of Residence	-Actual
8.	Medicare Status Code	-Aged only - no ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim
10.	Record Identification Code	-Part A -Part B
11.	Diagnostic Code	Code assigned from ICD-9-CM, Volumes I and II
12.	Multiple Diagnosis Code	-No -Yes -Unknown

Exhibit G

	Information	Description
13.	Period From Date	Year and Julian from date of billing period
14.	Period Thru Date	Year and Julian thru date of billing period
15.	Status Code	-Discharged alive -Died -Still Receiving Services
16.	Visits and Charges	For each category:
	A. Skilled Nursing Care B. Physical Therapy C. Speech Therapy D. Occupational Therapy E. Medical Social Services F. Home Health Aide G. Other Visits (1) Other Visits (2)	-Number of Visits -Dollars and Cents
17.	Total Visits	Total visits for all services
18.	Total Visit Charges	Total charges for HHA visits
19.	Other Charges	Total other charges
20.	Total Charges	Total charges including other charges
21.	Reimbursement Amount	An interim payment made to the institution. Final reimbursement is made on a cost basis based on the cost report each institution is required to prepare at the end of their fiscal year.

APPENDIX A: GLOSSARY

Accommodation Charges - The routine hospital room and board charges (including charges for nursing services).

Ancillary (Departmental) Charges - Those charges, other than routine room and board charges which are incidental to the hospital stay, including: operating room; anesthesia; outpatient services; blood administration; pharmacy; radiology; laboratory; medical, surgical and central supplies; physical therapy; occupational therapy; speech pathology; inhalation therapy; and "other".

Area of Residence - The county and State of the beneficiary based upon the mailing address used for cash benefits or the mailing address used for other purposes, e.g., premium billing. In some cases it may not be the actual area of beneficiary residence, e.g., if the beneficiary has a representative payee.

Assignment - Under Supplementary Medical Insurance (Part B), if the beneficiary and the provider (physician or supplier) both agree, the beneficiary may assign his rights to benefits to the provider. When this assignment method is used, the provider agrees that his total charge for the covered service will be the reasonable charge approved by the carrier. The provider submits a claim to the carrier, and is reimbursed for the reasonable charge, minus the 20 percent coinsurance and any deductible which remains unmet. The provider may then charge the beneficiary only for the coinsurance and any applicable deductible.

Benefit Period (Spell of Illness) - A period of time for measuring use of Hospital Insurance benefits. It begins on the entitled beneficiary's admission to a qualifying hospital or other facility and ends after the 60 consecutive days during which the individual was not an inpatient of any hospital or other facility primarily providing skilled nursing or rehabilitation services. Although there are limits to covered benefits per benefit period, there is no limit to the number of benefit periods a beneficiary can have. The beneficiary must pay the Hospital Insurance deductible for each new benefit period.

Beneficiary Identification Code (BIC) - A one or two position code that identifies the type of social security or railroad board benefits to which the beneficiary is entitled. The Social Security number of the primary beneficiary plus the BIC subscript represents the beneficiary's Health Insurance claim number.

Carrier - A private or public organization with which HCFA enters into agreement to help administer the Part B benefits under Medicare. Also referred to as "contractors," the carriers determine coverage and benefit amounts payable and make payment to physician/suppliers or beneficiaries.

Coinsurance - That portion of covered hospital and medical expenses, after subtraction of any deductible, for which the beneficiary is responsible. Under Hospital Insurance, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under Supplemental Medical Insurance, after the annual deductible has been met, Medicare will generally pay 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the beneficiary.

Cross-Reference Number - A Health Insurance Claim Number related to the current number. In cases where an individual becomes entitled under a new number (for example, a woman formerly entitled under her husband's number becomes entitled under her own number), the actions under both are recorded under the current (new) number.

Deductible - The amount payable by the beneficiary for covered services before Medicare makes reimbursement. The Part A deductible is the initial amount in each benefit period which Medicare does not pay. The Part B deductible is the portion of reasonable charges (for covered services each calendar year) for which a beneficiary is responsible. These amounts, currently fixed by law, usually differ from year to year.

Diagnosis Related Groups (DRGs) - Each Diagnosis Related Group represents a broad clinical category based on body system involvement and disease etiology which are similar in use of resources. There are 467 valid categories and three catch-alls. The following guidelines were used: (1) they must have been clinically consistent; (2) they must have had a sufficient number of patients; and (3) they must have covered the complete range of diagnoses represented in the ICD-9-CM, without overlap. They were developed by a Yale University research team and revised by Health Services International, Inc.

Disabled - For purposes of enrollment under Medicare, individuals under age 65 who have been entitled to disability benefits under the Social Security Act or the railroad retirement System for at least two years are considered to be disabled.

End-Stage Renal Disease (ESRD) - For purposes of enrollment under Medicare, individuals who have chronic kidney disease requiring renal dialysis or kidney transplant are considered to have end-stage renal disease. To qualify for Medicare coverage, the individual must be fully or currently insured under social security or the railroad retirement system, or be the dependent of an insured person. Eligibility for Medicare coverage begins with the third month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility; or if a person received a kidney transplant without starting or receiving dialysis.

Entitlement Date - The first day of the month in which an individual is entitled to Hospital Insurance (Part A) and/or Supplementary Medical Insurance (Part B) benefits.

General Enrollment Period (GEP) - An open season period between January 1 and March 31 each year for enrollment of individuals who missed initial enrollment, were terminated, or cancelled coverage voluntarily. (This procedure applies to Part B and voluntary Part A coverage for uninsured persons).

Group Practice Prepayment Plan (GPPP) - An organization which has a formal arrangement with three or more full-time physicians to provide certain health services to the plan's members who, through the advance payment of premiums or dues, have contributed toward the cost of services.

Health Insurance Claim Number (HIC) - The individual identification number used in the Medicare program to identify each beneficiary. It consists of a Social Security or Railroad account number plus a Beneficiary Identification Code (BIC) that denotes the type of beneficiary for cash payment programs. Most HIC's are 9 digit numbers with letter suffixes and are issued by the Social Security Administration (SSA); those issued by the Railroad Retirement Board (RRB) can be either a 6 or 9 digit number with letter prefixes.

Health Insurance Master Record (HIM) - The HCFA master Medicare file of all individuals in current entitlement status as well as those who have ever been entitled to Hospital Insurance (Part A) and/or Supplemental Medical Insurance (Part B) benefits.

Health Maintenance Organization (HMO) - An organization which provides services to Medicare beneficiaries on a prepaid per capita basis. The HMO will provide both Part A and Part B services and can contract to operate as a "risk-basis" HMO (sharing in any savings it achieves) or a "cost-basis" HMO (with no provision for achieving savings or incurring losses).

Home Health Agency (HHA) - A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home, such as: physical, occupational, or speech therapy; medical social services and home health aid services.

Hospital Insurance (HI) - HI (also known as Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for not less than 24 months to benefits under the social security or railroad retirement systems on the basis of disability, and for certain other individuals who are medically determined to have end-stage renal disease and are covered by the social security or railroad retirement systems.

Interim Bill - A bill that does not cover a complete stay in a hospital or skilled nursing facility. It is used when the beneficiary is still receiving services, i.e, has not yet been discharged.

Intermediary - A private or public organization with which HCFA enters into agreement to help administer benefits to institutional providers under the Health Insurance program. The intermediaries determine costs for Part A benefits and make payment to providers.

Lifetime Reserve Days (LRD) - A beneficiary is entitled to 60 hospital lifetime reserve days for inpatient hospital care. At the time regular benefits are exhausted, the patient chooses whether or not to exercise the use of the reserve days. Medicare does not pay for the entire day; the beneficiary pays one half of the inpatient deductible. The beneficiary can use up to a maximum of 60 lifetime reserve days during their lifetime.

Master Beneficiary Record (MBR) - The basic social security master file of all retirement, survivor, disability and health insurance beneficiaries. It is the source file for beneficiaries entitled to Medicare on the Health Insurance Master Record (HIM). HI beneficiary entitlement data, as well as termination, maintenance and premium billing and collection transactions, are processed and exchanged on an on-going basis between HCFA and SSA via the HI system and MBR interface.

Open Item - A record of admission to a hospital or skilled nursing facility for which a related discharge bill has not yet been received.

Outpatient Services - The medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Periodic Interim Payment (PIP) - A type of payment which furnishes providers with reimbursement for services more quickly than other arrangements. Intermediaries make payment bi-weekly, generally based on a per-inpatient-day rate calculated on estimated cost minus projected deductibles and coinsurance payable by the beneficiary for the services provided.

Premium - A monthly fee paid by Medicare beneficiaries. Part B beneficiaries pay a monthly premium which is updated every July to reflect any changes in program costs. Part A beneficiaries who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums.

Principal Diagnosis - The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Principal Surgical Procedure - The procedure that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or that which was necessary to take care of a complication.

Professional Standards Review Organization (PSRO) - The non-profit physician review organization responsible for reviewing the medical necessity, appropriateness, and quality of health care services provided to Medicare beneficiaries by the provider of services. This is essentially the same function performed by Peer Review Organizations (PRO).

Provider of Service - An institution that furnishes Part A and or Part B health services to Medicare beneficiaries. All such institutions must meet the applicable eligibility requirements of Title XVIII of the Social Security Act and regulations issued thereunder. Hospitals, Skilled Nursing Facilities, Home Health Agencies and Independent Laboratories are examples of providers.

Query - The record sent by the intermediaries and carriers to HCFA Central Office to verify eligibility and coverage. Intermediaries, upon receipt of a hospital admission notice, must determine if the admitted patient is an eligible Medicare beneficiary and if so, the amounts of related deductibles and coverage. This is accomplished by reporting the admission date to HCFA Central Office for screening against the Health Insurance Master file. Information pertaining to entitlement, deductible status and coverage is returned to the appropriate intermediary. Carriers, upon receipt of a bill for medical services rendered, must also determine if the recipient of the services is an eligible Medicare beneficiary and, if so, the status of their deductibles. The carrier reports the medical services data to HCFA Central Office for screening against the Health Insurance Master file and receives, in return, information pertaining to entitlement and deductible status.

Railroad Retirement Board (RRB) Number - A distinctive number assigned by the RRB to identify the accounts of individuals entitled to benefits under its system. The RRB number may be either a six or a nine digit number, and when used as claim numbers, appears in conjunction with an applicable RRB Beneficiary Identification Code (BIC).

Reasonable Charge - An individual charge determination made by a carrier on a covered Part B medical service or supply. In the absence of unusual medical complications or circumstances it is the lowest of 1) the physician's or supplier's customary charge for that service; 2) the prevailing charge of the physician or supplier rendering the service.

Reasonable Cost - In processing claims for HI benefits, intermediaries use HCFA guidelines to determine the reasonable cost incurred by the individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the health insurance program.

Reimbursement Amount - The amount reported as being paid by the Medicare program to or on behalf of the beneficiary for services provided by the physician or other provider of service including institutions. For institutional providers, this is usually an interim amount which is adjusted at the end of the provider's fiscal year based on its cost report. Beginning October 1983, for most hospitals, this amount will be based on the DRG.

Skilled Nursing Facility (SNF) - A specially qualified institution which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services and which meets specified regulatory certification requirements.

State Buy-In - Term given to the process by which a State may provide Supplementary Medical Insurance (SMI) coverage for it's needy, eligible persons through an agreement with the Federal government under which the State pays their premiums.

Supplementary Medical Insurance (SMI) - SMI (also known as Part B) is a voluntary insurance program which provides insurance benefits for physician and other medical services in accordance with the provisions of Title XVIII of the Social Security Act for aged and disabled individuals who elect to enroll under such program.

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